MOTO HEALTH CARE

REGISTRATION NUMBER: 1600

ANNUAL FINANCIAL STATEMENTS

31 DECEMBER 2015

MOTO HEALTH CARE

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2015

The reports and statements set out below comprise the annual financial statements and report of the Board of Trustees presented to members:

MOTO HEALTH CARE

REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2015

DESCRIPTION OF THE MEDICAL SCHEME

The Moto Health Care Medical Scheme is a not for profit restricted membership Medical Scheme, registered in terms of the South African Medical Schemes Act 131 of 1998, as amended.

The Scheme provides 5 benefit options to its members :

Optimum option
Classic option
Hospicare option
Custom option
Essential option

The Scheme entered into a risk transfer arrangement in 2009 with Carecross Health Pty Ltd to provide basic primary care to the members on the Essential and Custom options, and chronic medication and specialist out of hospital treatment to members on the Custom option. The service is billed at an inflation adjusted National Reference Price List (NRPL) rates and the difference between the services provided and the fixed amount paid is the risk transfer profit or loss. Further details of the financial results of this arrangement are set out in Note 11 to the annual financial statements.

The Custom and Essential options have exemptions for prescribed minimum benefits.

The Classic option has a savings account. Savings contributions are refundable upon a member enrolling in another benefit option or a medical scheme without a personal savings account or if the member does not enrol in another medical scheme, the money is transferred to the member in terms of the medical scheme rules.

BOARD OF TRUSTEES IN OFFICE DURING THE YEAR UNDER REVIEW

B Canning	(Chairman)	
H Lombard		
W Schroeder		
D Simpson	Newly elected on 11 June 2015	
R Strydom	Newly elected on 11 June 2015	
E Philips	Newly elected on 11 June 2015	
J Mthimunye	Term expired on 11 June 2015	
A van der Rheede	Term expired on 11 June 2015	
E Kubeka	Term expired on 11 June 2015	
M Roberts	Term expired on 11 June 2015	
R Sibiya	Term expired on 11 June 2015	
S Tsiane	Term expired on 11 June 2015	
J Olivier	Term expired on 11 June 2015	Appointed 01/07/15-16/09/15
J Schoeman	Term expired on 11 June 2015	Appointed 01/07/15-16/09/15

The General Rules have been revised and approved on 16 September 2015 to provide for 8 member trustees elected from members. The first 6 trustees served on the Board with 2 vacancies for the remainder of the year.

PRINCIPAL OFFICER

Mr DFA van Tonder
279 Kent Avenue
Randburg
2125

PO Box 3882
Randburg
2125

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

REGISTERED OFFICE AND POSTAL ADDRESS OF THE SCHEME

Street Address	**Postal Address**
279 Kent Avenue	PO Box 3882
Randburg	Randburg
2125	2125

ADMINISTRATOR

Momentum Medical Scheme Administrators Pty Ltd, a wholly-owned subsidiary of the MMI Group Ltd

1-3 Canegate Road	PO Box 2338
La Lucia Ridge	Durban
4019	4000

INVESTMENT CONSULTANTS

Selekane Asset Consultants	PO Box 522118
Ground Floor, Lansdown House	Saxonwold
Hampton Park	2132
20 Georgian Crescent	
Bryanston	
2152	FSP number : 29848

INVESTMENT MANAGERS

Old Mutual Investment Group

Jan Smuts Drive (West entrance)	PO Box 878
Pinelands	Cape Town
7405	8000
	FSP number : 604

Vunani Fund Managers

6th Floor, Letterstedt House	P O Box 44586
Newlands on Main	Claremont
Newlands	7735
7700	FSP number : 608

Taquanta Asset Managers

7th Floor, Newlands Terraces	PO Box 23540
Boundary Road	Claremont
Newlands	7735
7700	FSP number : 918

ACTUARIES

Momentum Group Health Actuarial	
268 West Avenue	PO Box 7400
Centurion	Centurion
0157	0157

Independent Actuary

R da Silva and Associates
43 French Lane
Morningside
2196

PO Box 70929
Bryanston
2021

AUDITOR

Ernst & Young Inc.
1 Pencarrow Crescent
Pencarrow Park
La Lucia Ridge
4019

PO Box 859
Durban
4000

RESERVE ACCOUNTS

Movements in the reserves are set out in the statement of changes in funds and reserves. There have been no unusual movements that the Board of Trustees believe should be brought to the attention of the members. The solvency ratio at 31 December 2015 was 54.4% (2014: 53.5%).

REVIEW OF THE YEAR'S ACTIVITIES

The results of the Scheme are set out in the attached annual financial statements, and the Board of Trustees believes that no further clarification is needed.

SOLVENCY RATIO

The solvency ratio is calculated on the following basis:

	2015 R'000	2014 R'000
Total members' funds per statement of financial position	446 224	445 247
Less: Cumulative unrealised net gains on re-measurement to fair value of financial instruments	-	(12 270)
Accumulated funds per Regulation 29	446 224	432 977
Gross contributions	820 613	809 972
Solvency ratio	54.4%	53.5%

(Accumulated funds - Cumulative unrealised gains)/Gross annual contribution income x 100)

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

INVESTMENT STRATEGY OF THE MEDICAL SCHEME

The Scheme's investment objectives are to maximise the return on its investments on a long term basis at minimal risk. The investment strategy takes into consideration both constraints imposed by legislation and those imposed by the Board of Trustees.

The Scheme appointed an asset consultant and has mandated the consultant to ensure that :

- the Scheme remains liquid;
- investments are placed at minimum risk with the best possible return; and
- investments made are in compliance with the regulations of the Act.

The Scheme has investments in money market instruments, cash and deposits, bonds and shares.

INSURANCE RISK MANAGEMENT

The primary insurance activity carried out by the Scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. This risk relates to the health of the Scheme members. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of risk transfer arrangements, and the monitoring of emerging issues.

The Scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims are greater than expected.

RELATED PARTY TRANSACTIONS

Refer to related party disclosure in Note 19 to the annual financial statements.

INVESTMENTS IN AND LOANS TO PARTICIPATING EMPLOYERS OF MEMBERS OF THE MEDICAL SCHEME AND OTHER RELATED PARTIES

The Scheme holds no direct investments in or loans to participating employers of Scheme members or other related parties.

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

The following schedule sets out the composition of the Board of Trustees and audit committee, and their respective meeting attendances.

	Board of Trustee Meetings		Audit Committee Meetings	
Trustees	**A**	**B**	**A**	**B**
B Canning	7	7		
E Kubeka	4	3		
H Lombard	7	7		
D Simpson	3	3	1	1
R Strydom	3	3	2	2
E Philips	3	3		
J Mthimunye	4	4		
J Olivier	5	5	1	1
M Roberts	4	3	1	1
J Schoeman	6	6		
W Schroeder	6	6		
R Sibiya	4	4		
S Tsiane	4	4	1	0
A van der Rheede	4	4		
Independent members				
I Catt			3	3
J Kotze			3	3
G Franck			3	2
M Mafojane			3	3

A - total possible number of meetings could have attended
B - actual number of meetings attended

AUDIT COMMITTEE
An audit committee was established in accordance with the provisions of the Medical Schemes Act 131 of 1998. The Board of Trustees mandates the audit committee by means of written terms of reference as to its membership, authority, and duties. The committee consists of six members of which two are members of the Board of Trustees. The majority of the members, including the chairperson, are not officers of the Scheme. The committee met on three occasions during the year under review.

The chairperson of the Medical Scheme Board of Trustees, the principal officer, financial manager of the Medical Scheme, the internal and external auditors are invited to attend all committee meetings, and have unrestricted access to the chairperson of the committee.

In accordance with the provisions of the Act, the primary responsibility of the committee is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The internal and external auditors formally report to the committee on critical findings arising from the audit activities.

The audit committee presently comprises of the following:

I Catt (Independent Chairman)
G Franck (Independent)
J Kotze (Independent)
M Mafojane (Independent)
D Simpson (Trustee)
R Strydom (Trustee)

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

OPERATIONAL STATISTICS 2015

	2015					
	Essential Option	Custom Option	Hospicare Option	Classic Option	Optimum Option	Total Scheme
Number of members at the end of the accounting period	4 286	8 694	916	9 742	1 514	25 152
Number of beneficiaries at the end of the accounting period	9 185	19 392	1 572	21 524	3 074	54 747
Average number of members for the accounting period	4 436	8 754	949	9 972	1 568	25 679
Average number of beneficiaries for the accounting period	9 460	19 634	1 637	22 079	3 213	56 023
Average net contribution per beneficiary per month (pbpm)	R250	R650	R1 133	R1 433	R3 412	R1 063
Pensioner ratio (beneficiaries age > 65)	0.5%	4.3%	41.7%	14.7%	25.3%	10.0%
Average age per beneficiary	29.48	29.43	52.38	39.00	47.93	34.90
Relevant healthcare expenditure per average beneficiary	R1 883	R6 803	R17 041	R16 604	R40 450	R12 064
Non healthcare expenditure per average beneficiary	R436	R869	R1 353	R1 552	R2 420	R1 168
Average accumulated funds per member at the end of the accounting period #						R17 741
Dependants per member at the end of the accounting period	1.14	1.23	0.72	1.21	1.03	1.18
Return on investments as a % of investments #						6%
Non healthcare expenditure as a percentage of gross contributions	15%	11%	10%	7%	6%	8%
Relevant healthcare expenditure as a percentage of risk contributions	63%	87%	125%	97%	99%	95%

- ratio not presented per policy

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

OPERATIONAL STATISTICS 2014

	2014					
	Essential Option	Custom Option	Hospicare Option	Classic Option	Optimum Option	Total Scheme
Number of members at the end of the accounting period	4 696	8 636	1 056	10 185	1 693	26 266
Number of beneficiaries at the end of the accounting period	10 046	19 427	1 857	22 632	3 499	57 461
Average number of members for the accounting period	4 807	8 630	1 076	10 525	1 759	26 797
Average number of beneficiaries for the accounting period	10 300	19 481	1 886	23 430	3 659	58 756
Average net contribution per beneficiary per month (pbpm)	R228	R594	R990	R1 335	R3 207	R1 001
Pensioner ratio (beneficiaries age > 65)	0.5%	4.2%	37.6%	13.9%	23.2%	9.6%
Average age per beneficiary	29.4	29.45	49.96	38.46	46.58	33.80
Relevant healthcare expenditure per average beneficiary	R1 744	R6 263	R16 126	R16 018	R35 647	R11 507
Non healthcare expenditure per average beneficiary	R422	R802	R1 368	R1 490	R2 379	R1 126
Average accumulated funds per member at the end of the accounting period #						R16 951
Dependants per member at the end of the accounting period	1.14	1.25	0.76	1.22	1.07	1.19
Return on investments as a % of investments #						6%
Non healthcare expenditure as a percentage of gross contributions	15%	11%	12%	7%	6%	9%
Relevant healthcare expenditure as a percentage of risk contributions	64%	88%	136%	100%	93%	96%

- ratio not presented per policy

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

ACTUARIAL SERVICES

The Scheme's actuaries are contracted to assit the Board of Trustees to determine the appropriate contribution and benefit levels for the Scheme. They also monitor health related risks and establish claiming patterns in order to determine the claims incurred but not reported (IBNR) provision.

FIDELITY COVER

The Scheme has fidelity cover in place and the premiums are fully paid up.

EVENTS AFTER REPORTING DATE

There are no significant events after reporting date, 31 December 2015, to report on.

NON-COMPLIANCE WITH MEDICAL SCHEMES ACT 131 of 1998

The following areas of non-compliance of the Medical Schemes Act 131, 1998 were identified during the course of the year, none of which were, in the opinion of the Board of Trustees of a significant nature:

1. Benefit options in loss making position

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 33 (2) it is a requirement that each individual benefit option should be financially sound.

The Scheme has benefit options that are in a loss making position at a net healthcare result level at year end and are therefore indirectly subsidised by the other benefit options. The contravention of the Act may be to the detriment of some of the members on the Scheme, but this situation is common in the industry.

Causes of failure

The affected benefit options risk profiles are worse than the average of the total Scheme, resulting in a worse than anticipated financial position.

Corrective action

The Scheme informs the Council for Medical Schemes (CMS) of these challenges. The Scheme is committed to rectify the situation through marketing and benefit design.

2. Contributions received within 3 days of becoming due

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 26(7) it is a requirement that contributions should be received within three days of becoming due.

During the year under review there were instances where premiums were not received within the three days as prescribed by the Act.

Causes of failure

The reason for this is due to the inherent nature of the business.

Corrective action

The Scheme through its administrators has implemented adequate credit control policies and procedures to minimise the risk of non recoverability. The risk is considered insignificant by the Board of Trustees.

3. Claims paid within 30 days of receipt

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 59(2) it is a requirement that claims should be paid within 30 days of receipt thereof. Instances were noted where claims were paid after 30 days of receipt.

Causes of failure

Claims are generally paid within this 30 day requirement, but due to certain procedures such as clinical auditing, there are exceptions where certain claims are paid after 30 days of date of receipt.

Corrective action

The Scheme has acknowledged that since it only applies to a few claims where such procedures are necessary to validate claims, this risk is considered insignificant.

4. Limitation of assets

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Regulation 35(8)(c), a medical scheme shall not invest any of its assets in the business of or grant loans to any administrator. As at the 31 December 2015, the Scheme had investments in administrators.

Causes of failure

The Scheme appointed reputable asset managers who are managing the investment portfolios to the best interest of the Scheme. The Scheme does not influence the asset manager on the selection of shares or instruments in the portfolio which sometimes includes shares listed on the JSE of insurance companies with an interest in an administrator of a medical scheme.

Corrective action

The Scheme obtained an exemption from the provision of Regulation 35(8)(c) from CMS and therefore does not consider this a non-compliance.

5. Prescribed Minimum Benefits (PMB)

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Regulations 8(1) and 10(6), Prescribed Minimum Benefits must be paid in full and cannot be paid from a member's savings account. During sample testing instances were noted where Prescribed Minimum Benefits were not paid in full and were paid from member's savings accounts.

Causes of failure

The administration system has been set up to settle all PMB claims according to Scheme rules. It is acknowledged that identifying a claim as a PMB is a complex issue given the lack of a workable industry (ICD10) coding system. Many PMB's cannot initially be correctly identified as PMB's based on the ICD10 codes provided.

Corrective action
The Scheme and administrator continue to monitor the payment of PMB claims in order to ensure the best outcome for the member and the Scheme. Adjustments are made when additional medical evidence is provided as confirmation of a PMB.

6. Fees payable to brokers

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 65 and Regulation 28 , a medical scheme is prohibited to compensate brokers for the period during which they are suspended. Thethani was paid from January to March 2015, whilst they were suspended due to their deaccreditation.

Causes of failure

The Scheme was unaware of the fact that the brokers at Thethani were unaccredited, hence were suspended from performing broker services and all payments to Thethani were made as normal by the Scheme. The Scheme members were still being serviced during this period.

Corrective action

The Scheme has post year end recovered all payments made to Thethani, while being unaccredited. Thethani reapplied for accreditation and has been subsequently accredited.

LITIGATION

There was litigation in progress as at 31 December 2015 against Calabash Health Solutions (Pty) Ltd, which has been ongoing since 2007. The Scheme is attempting to recover outstanding funds due from Calabash as a result of a past capitation agreement with the Scheme. The approximate value of the outstanding debt amounts to R30 million. This debt has been fully impaired in the financial statements of 2007 and any recoveries will be disclosed as bad debt recovered.

OUTSTANDING CLAIMS PROVISION

The outstanding claims provision is a provision for the estimated cost of healthcare benefits that have occurred before the reporting date but have not been reported to the Scheme by that date. The provision is determined as accurately as possible based on a number of assumptions. This basis of determination is consistent with prior years. Refer to Note 8 for further details.

GENERAL

The Chairperson of the Board of Trustees would like to thank the Board of Trustees members and the members of the Audit Committee for the positive and meaningful contributions during the year.

MOTO HEALTH CARE

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES
for the year ended 31 December 2015

The Board of Trustees is responsible for the preparation, integrity and fair presentation of the annual financial statements of Moto Health Care. The annual financial statements presented on pages 15 to 49 have been prepared in accordance with International Financial Reporting Standards and the Medical Scheme's Act of South Africa and include amounts based on judgements and estimates made by management.

The Board of Trustees consider that in preparing the annual financial statements they have used the most appropriate accounting policies, consistently applied and supported by reasonable and prudent judgements and estimates.

The Board of Trustees is responsible for ensuring that proper accounting records are kept. The accounting records disclose with reasonable accuracy the financial position of the Scheme which enables the Board of Trustees to ensure that the annual financial statements comply with relevant legislation.

Moto Health Care operates in a well-established control environment, which is well documented and regularly reviewed. This incorporates risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the business are being controlled.

Based on the results of the formal documented review of the Scheme's system of internal controls and risk management, the Board is of the opinion that the Scheme's system of internal controls and risk management is effective and that the internal financial controls form a sound basis for the preparation of reliable financial statements. The Board's opinion is supported by the audit committee.

The going concern basis has been adopted in preparing the annual financial statements. The Board of Trustees has no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on forecasts and available cash resources. These annual financial statements support the viability of the Scheme.

The Board of Trustees is satisfied that the information contained in the annual financial statements fairly presents the results of operations and cash flows for the year then ended and the financial position of the Scheme at year end. The Board of Trustees also prepared the other information included in the annual financial statements.

The Scheme's external auditor, Ernst and Young Inc. are responsible for auditing the annual financial statements in terms of International Standards on Auditing and their audit report is presented on page 14.

The annual financial statements were approved by the Board of Trustees on 20 April 2016 and are signed on its behalf by:

B Canning
Chairman

W Schroeder
Board of Trustees Member

D van Tonder
Principal Officer

MOTO HEALTH CARE

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES
for the year ended 31 December 2015

Moto Health Care is committed to the principles and practice of fairness, openness, integrity, ethical behaviour and accountability in all dealings with its stakeholders.

Board of Trustees

The Board of Trustees meets regularly and monitors the performance of the Scheme and the administrators. They address a range of key issues and ensure that discussion of items of policy, strategy and performance is critical, informed and constructive.

All Board of Trustees members have access to the advice and services of the Principal Officer and where The Board of Trustees considers it appropriate, may seek independent professional advice at the expense of the Scheme.

The Scheme adheres to the governance framework set out in the King report on governance for South Africa and the King Code of Governance Principles (King III).

Internal Control

The administrators of the Scheme maintain internal controls and systems designed to provide reasonable, but not absolute, assurance as to the integrity and reliability of the annual financial statements and to adequately safeguard, verify and maintain accountability for its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

A formal internal audit function exists within the administrator, with regular reporting to the Audit Committee. The administrator of the Scheme has documented and tested disaster recovery procedures and the Board is satisfied that the procedures are in place and tested.

No event or item has come to the attention of the Board of Trustees that indicates any material breakdown in the functioning of key internal controls and systems during the year under review.

Risk Management

Risk Assessment

The Board of Trustees used a structured methodology to assess the Scheme's risks. In addition to the financial risks expanded on under Note 21 and 22 to the annual financial statements, the main risks identified by this process as at 31 December 2015 are :

- Continued loss of membership due to economic downturn
- Worsening of Macro environment issues like medical inflation, NHI perceptions and Regulations
- Additional competition, both external to and within the industry as Moto Health Care is a Voluntary Scheme
- Negative impact of Industry demographics like average age and PMB conditions
- Negative impact of technological advances on issues like fraud risk

Risk Response

An appropriate system of internal control has been established by the Scheme's administrator to manage the Scheme's significant risks. This provides reasonable assurance that the Scheme's business objectives will be met, even in the event of a disastrous incident impacting on activities.

Risks are further controlled and managed by policies limiting exposure in specific areas such as finance, administration, claims handling and payments, information systems, treasury, and human resources, as well as external and internal insurance programmes.

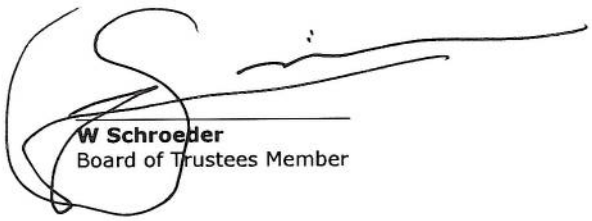
STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2015

Risk Management (continued)

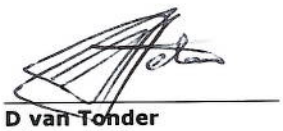
Risk Response (continued)

The Scheme's administrator seeks to have a sound system of internal control, based on its policies and guidelines, in all material associates and contractors. Where this is not possible, the responsible directors of the Scheme's administrator seek assurance that significant risks are being managed in an acceptable manner, and provide bi-annual confirmation to the Scheme's Board of Trustees that such significant risks are being effectively managed.

B Canning
Chairman



W Schroeder
Board of Trustees Member



D van Tonder
Principal Officer

20 April 2016

EY
Building a better working world

EY
1 Pencarrow Crescent
La Lucia Ridge Office Park
PO Box 859
Durban
4000

Ernst & Young Incorporated
Co. Reg. No. 2005/002308/21
Tel: +27 31 576 8000
Fax: +27 31 576 8300
Docex 117 Durban
www.ey.com

REPORT OF THE INDEPENDENT AUDITOR TO THE MEMBERS OF MOTO HEALTH CARE

Report on the financial statements

We have audited the financial statements of Moto Health Care as set out on pages 15 to 49, which comprise the statement of financial position as at 31 December 2015, and the statement of comprehensive income, statement of changes in funds and reserves and statement of cash flows for the period then ended, a summary of significant accounting policies and other explanatory information.

Trustees' responsibility for the financial statements

Moto Health Care's Trustees are responsible for the preparation and fair presentation of these financial statements in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act of South Africa, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the trustees, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Moto Health Care as at 31 December 2015, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes of South Africa.

Report on other legal and regulatory requirements

As required by the Council of Medical Schemes, we draw your attention to note 24, instances of non-compliance with the Medical Schemes Act of South Africa.

Other reports required by the Medical Schemes Act

As part of our audit of the financial statements for the year ended 31 December 2015, we have read the Board of Trustees' Report for the purpose of identifying whether there are material inconsistencies between this report and the audited financial statements. This report is the responsibility of the respective preparers. Based on reading this report we have not identified material inconsistencies between this report and the audited financial statements. However, we have not audited this report and accordingly do not express an opinion on this report.

ERNST & YOUNG INC.

Ernst & Young Inc.
Director: Merisha Kassie
Registered Auditor
Chartered Accountant (SA)

20 April 2016
Durban

MOTO HEALTH CARE

STATEMENT OF FINANCIAL POSITION
at 31 December 2015

	Notes	2015 R	2014 R
ASSETS			
Non-current assets		280 000	316 900
Furniture and equipment	2	280 000	316 900
Current assets		566 249 043	562 349 792
Trade and other receivables	3	34 335 364	38 531 472
Investments held at fair value through surplus or deficit	4	300 394 644	330 788 659
Cash and cash equivalents	5	165 620 862	135 004 781
Personal medical savings trust investments	6	65 898 173	58 024 880
Total assets		566 529 043	562 666 692
FUNDS AND LIABILITIES			
Accumulated Funds		446 223 790	445 247 165
Current liabilities		120 305 253	117 419 527
Personal medical savings account trust monies	6	65 493 748	57 857 547
Trade and other payables	7	6 930 118	10 693 352
Outstanding claims provision	8	47 881 387	48 868 628
Total funds and liabilities		566 529 043	562 666 692

MOTO HEALTH CARE

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2015

	Notes	2015 R	Restated 2014 R
Risk contribution income	9	714 888 846	705 503 126
Relevant healthcare expenditure		(675 838 657)	(676 116 694)
Net claims incurred	10	(673 797 230)	(675 231 981)
Risk claims incurred		(674 872 172)	(675 957 023)
Third party claim recoveries		1 074 942	725 042
Managed care: management services	12	(17 777 380)	(17 305 280)
Net income on risk transfer arrangements	11	15 735 953	16 420 567
Risk transfer arrangement expenses		(60 685 405)	(58 017 664)
Claim recoveries from risk transfer arrangement		76 421 358	74 438 231
Gross healthcare result		39 050 189	29 386 432
Administration expenses	13	(61 210 154)	(60 644 328)
Broker service fees	14	(3 299 964)	(4 484 212)
Net impairment losses on healthcare receivables	15	(918 703)	(1 037 723)
Net healthcare result		(26 378 632)	(36 779 831)
Other income		34 362 141	31 508 348
Sundry income		2 892 619	63 500
Investment income	16	29 696 782	30 503 394
Fair value adjustment	17	1 772 740	941 454
Other expenditure		(7 006 884)	(6 192 886)
Investment management fees	16.1	(2 739 938)	(2 878 010)
Interest paid on savings balances	6	(4 266 946)	(3 314 876)
Net surplus/(deficit) for the year		976 625	(11 464 369)
Other comprehensive income		-	-
Total comprehensive surplus/(deficit) for the year		**976 625**	**(11 464 369)**
Solvency ratio		**54.4%**	**53.5%**

MOTO HEALTH CARE

STATEMENT OF CHANGES IN FUNDS AND RESERVES
for the year ended 31 December 2015

	Accumulated funds R
Balance as at 1 January 2014	456 711 534
Total comprehensive deficit for the year	(11 464 369)
Balance as at 31 December 2014	445 247 165
Total comprehensive surplus for the year	976 625
Balance as at 31 December 2015	446 223 790

MOTO HEALTH CARE

STATEMENT OF CASH FLOWS
for the year ended 31 December 2015

	Note	2015 R	2014 R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flow from operations before working capital changes	18	(7 321 550)	(26 505 027)
Working capital changes			
- Decrease in trade and other receivables		4 196 108	1 573 916
- (Decrease)/increase in savings plan net liability		(237 092)	2 647 080
- (Decrease)/increase in trade and other payables		(3 763 235)	211 090
Cash flows from operations		(7 125 769)	(22 072 941)
Investment income		29 696 782	30 503 394
Investment management fees		(2 739 938)	(2 878 010)
Interest paid on members' savings accounts		(4 266 946)	(3 314 876)
Net cash flows from operations		15 564 129	2 237 567
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments	4	(226 391 788)	(23 183 000)
Proceeds on disposal of investments		241 443 740	2 056 924
Purchase of furniture and equipment	2	-	(3 988)
Cash flows from investment activities		15 051 952	(21 130 064)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		30 616 081	(18 892 497)
Cash and cash equivalents at beginning of the year		135 004 781	153 897 278
CASH AND CASH EQUIVALENTS AT END OF THE YEAR	5	165 620 862	135 004 781

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2015

1 PRINCIPAL ACCOUNTING POLICIES

These financial statements set out on pages 15 to 49 have been prepared in conformity with International Financial Reporting Standards (IFRS), Interpretations issued by the International Financial Reporting Interpretations Committee (IFRIC) and the Medical Schemes Act of 1998 as amended. The financial statements are presented in Rands, the functional currency of the Scheme, and all values are rounded to the nearest Rand.

1.1 Basis of preparation

The financial statements are prepared on the historical cost convention, except for investments held at fair value through surplus/deficit, which are carried at fair value. The financial statements have been prepared on the going concern basis.

1.2 Changes in accounting policies

The accounting policies adopted are consistent with those of the previous financial year. The following amendments applicable to the Scheme have become effective for the year under review and did not have a significant impact on the Scheme:

Standard	Subject
IAS 16	The IASB issued amendments to IAS 16 Property, Plant and Equipment, prohibiting the use of revenue-based depreciation methods for fixed assets. The amendments are effective prospectively.
IAS 24	The standard was amended to include, as a related party, an entity that provides key management personnel services to the reporting entity or to the parent of the reporting entity.
IFRS 13	Short term receivables and payables with no stated interest rates can be measured at invoice amounts when the effect of discounting is immaterial.

1.3 Significant accounting judgements, estimates and assumptions

The preparation of the Scheme's financial statements require management to make judgements, estimates and assumptions that affect the reported amounts of revenue, expenses, assets, and liabilities, and the disclosure of contingent liabilities, at the reporting date. However, uncertainty about these assumptions and estimates could result in outcomes that could require a material adjustment to the carrying amount of the asset or liability in the future.

Judgements

In the process of applying the Scheme's accounting policies, management have not made any judgements, apart from those involving estimations, which have a significant effect on the amounts recognised in the financial statements.

Estimates and assumptions

The key assumptions concerning the future and other key sources of estimation uncertainty at the reporting date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are as follows:

Furniture and equipment
Estimation is used in approximating the useful lives and residual values of furniture and equipment. These assessments are made on an annual basis and use historical evidence and current economic factors to estimate the values.

Estimates and assumptions(continued)

Impairment of trade and other receivables

The process of identifying impairment in trade and other receivable balances is the result of a process of estimating what debtors, based on actual events and evidence at year end, will not be able to meet their obligations in the future. Portfolio impairments are only made after the specific impairment has been made and overriding economic conditions indicate that the debtors balance as a whole might be impaired after the specific provision.

Outstanding claims provision

Claims outstanding comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date and related internal and external claims handling expenses. Claims outstanding are determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settling patterns, changes in the nature and number of members according to gender and age, trends in claims processing cycle, and variations in the nature and average cost incurred per claim.

1.4 Furniture and equipment

Furniture and equipment is stated at cost less accumulated depreciation and accumulated impairment losses. Such cost includes the cost of replacing part of the furniture and equipment when that cost is incurred, if the recognition criteria is met. All other repairs and maintenance costs are recognised in surplus or deficit as incurred.

Depreciation is calculated on a straight line basis over the estimated useful lives of the assets after taking into consideration the assets' residual value.

The estimated useful lives are :

Computer equipment	4-6 years
Office equipment	4-6 years
Furniture and fittings	10 years

The useful lives and residual values and depreciation methods of the assets are reviewed at least at each financial year end and any changes are accounted for as a change in estimate.

An item of furniture and equipment is derecognised upon disposal, or when no future economic benefits are expected from its use or disposal. Any gain or loss arising on de-recognition of the asset (calculated as the difference between the net disposal proceeds and the carrying amount of the asset) is included in surplus or deficit in the year the asset is de-recognised.

1.5 Financial instruments

Financial assets and liabilities are recognised on the Scheme's statement of financial position when it becomes a party to the contractual provisions of the instrument.

The Scheme's classification of financial instruments is as follows:

Description:	*Classification:*
Trade and other receivables	Loans and receivables
Cash and cash equivalents	Loans and receivables
Investments held at fair value through surplus/deficit	Fair value through surplus/deficit
Trade and other payables	Loans and borrowings

Fair value

The fair value of investments that are actively traded in organised financial markets is determined by reference to quoted market bid prices at the close of business on the reporting date. For investments where there is no active market, fair value is determined using valuation techniques. Such techniques include using recent arm's length market transactions, reference to the current market value of another instrument which is substantially the same, discounted cash flow analysis or other valuation model.

1.5 **Financial instruments (continued)**

Initial Measurement

Financial instruments are initially measured at fair value plus, in the case of financial assets and liabilities not at fair value through surplus or deficit, transaction costs that are directly attributable to acquisition or issue of the financial asset or liability. Subsequent to initial recognition, these instruments are measured as set out below.

Investments

All purchases and sales of investments are recognised on the trade date, which is the date that the Scheme commits to purchase or sell the asset. Financial assets held at fair value through surplus or deficit are subsequently carried at fair value. Realised and unrealised gains and losses arising from changes in the fair value of investments held at fair value through surplus or deficit are included in surplus or deficit in the period in which they arise.

Trade and other receivables

Trade and other receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial measurement, trade and other receivables are subsequently carried at amortised cost using the effective interest method less any allowance for impairment. Amortised cost is calculated taking into account any discount or premium on acquisition and includes fees that are an integral part of the effective interest rate and transaction costs. Gains and losses are recognised in surplus or deficit when the receivables are derecognised or impaired, as well as through the amortisation process.

Cash and cash equivalents

Cash and cash equivalents are subsequently measured at amortised cost and comprise current bank accounts, deposits held on call with banks, and other short-term liquid investments that are readily convertible to a known amount of cash and which are subject to an insignificant risk of change in value and bank overdrafts.

De-recognition of financial assets

A financial asset is derecognised when:

- The rights to receive cash flows from the asset have expired;
- The Scheme has transferred its rights to receive cash flows from the asset or has assumed an obligation to pay the received cash flows in full without material delay to a third party under a 'pass-through' arrangement; and either

(a) the Scheme has transferred substantially all the risks and rewards of the asset, or
(b) the Scheme has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

When the Scheme has transferred its rights to receive cash flows from an asset or has entered into a pass-through arrangement, it evaluates if and to what extent it has retained the risks and rewards of ownership. When it has neither transferred nor retained substantially all of the risks and rewards of the asset, nor transferred control of the asset, the asset is recognised to the extent of the Scheme's continuing involvement in the asset. In that case, the Scheme also recognises an associated liability. The transferred asset and the associated liability are measured on a basis that reflects the rights and obligations that the Scheme has retained.

Continuing involvement that takes the form of a guarantee over the transferred asset is measured at the lower of the original carrying amount of the asset and the maximum amount of consideration that the Scheme could be required to repay.

1.5 Financial instruments (continued)

Financial liabilities

Financial liabilities are initially measured at fair value, and are subsequently measured at amortised cost, using the effective interest rate method. Gains and losses are recognised in surplus or deficit when the liabilities are derecognised as well as through the amortisation process. Financial liabilities carried at amortised cost include trade and other payables.

De-recognition of financial liabilities

A financial liability is de-recognised when the obligation under the liability is discharged or cancelled or expires. When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as the derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised in the income statement.

Offset

Where a currently enforceable legal right of offset exists for recognised financial assets and financial liabilities, and there is an intention to settle the liability and realise the asset simultaneously or to settle on a net basis, all related financial effects are offset.

1.6 Provisions

Outstanding claims provision

Claims outstanding comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date and related internal and external claims handling expenses. Claims outstanding are determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to gender and age, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim. Estimated co-payments are deducted in calculating the outstanding claims provision.

The Scheme does not discount its provision for outstanding claims, since the effect of the time value of money is not considered material.

1.7 Personal medical savings account

The members personal medical savings account, which is managed by the Scheme on behalf of its members, represents savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules.

The deposit component of the insurance contracts has been unbundled, since the Scheme can measure the deposit component separately. The deposit component is recognised in accordance with IAS 39 and is initially measured at fair value and subsequently at amortised cost using the effective interest rate method. The insurance component is recognised in accordance with IFRS 4.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Act balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's reserves and the risk of impairment is carried by the Scheme.

The personal medical savings account monies are invested separately. These monies are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method.

1.8 Medical insurance contracts and liability adequacy test

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. The contracts issued compensate the Schemes members for healthcare expenses incurred.

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows and comparing this amount to the carrying value of the liability net of any related assets. Where a shortfall is identified, an additional provision is made and the Scheme recognises the deficiency in income for the year.

1.9 Contribution income

Contributions are accounted for based on the fair value of the consideration received monthly. The earned portion of net contributions received is recognised as revenue on the accrual basis. Net contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis.

1.10 Managed care: management services

These expenses represent amounts paid or payable to third party administrators, related parties and other third parties for managing the utilisation, costs and quality of healthcare services to the Scheme.

1.11 Claims

Gross claims incurred comprise the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether or not reported by the end of the year.

Net claims incurred comprise:

- claims submitted and accrued for services rendered during the year, net of recoveries from co-payments and savings plan accounts;
- claims for services rendered during the previous year not included in the outstanding claims for that year, net of recoveries from members for co-payments and savings plan accounts;
- movement in the provision for outstanding claims; and
- claims settled in terms of risk transfer arrangements.

Claims incurred relating to risk transfer arrangements are calculated on the basis of actual utilisation applied to an inflation adjusted National Health Reference Pricing.

1.12 Risk transfer arrangements

Risk transfer premiums are recognised as an expense over the indemnity period on a straight-line basis. Only contracts that give rise to a significant transfer of insurance risk are accounted for as insurance. Amounts recoverable under such contracts are recognised in the same year as the related claim.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. Such assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement.

1.12 **Risk transfer arrangements (continued)**

Risk transfer claims and benefits reimbursed are presented in the statement of comprehensive income and statement of financial position on a gross basis. Amounts recoverable under such contracts are recognised in the same year as the related claim. Claim recoveries under the risk transfer arrangement are determined by reports received from the service providers with all services rendered during the period.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions and claims reported not yet paid.

Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provisions, claims reported not yet paid and settled claims associated with the risk transfer arrangement.

1.13 **Impairment of financial assets**

The Scheme assesses at each reporting date whether there is any objective evidence that a financial asset or a group of financial assets is impaired. A financial asset or a group of financial assets is deemed to be impaired if, and only if, there is objective evidence of impairment as a result of one or more events that has occurred after the initial recognition of the asset (an incurred 'loss event') and that loss event has an impact on the estimated future cash flows of the financial asset or the group of financial assets that can be reliably estimated. Evidence of impairment may include indications that the debtors or a group of debtors is experiencing significant financial difficulty, default or delinquency in interest or principal payments, the probability that they will enter bankruptcy or other financial reorganisation and where observable data indicate that there is a measurable decrease in the estimated future cash flows, such as changes in arrears or economic conditions that correlate with defaults. The carrying amount of the asset is reduced through the use of an allowance account and the amount of the loss is recognised in surplus or deficit. If, in a subsequent year, the amount of the estimated impairment loss increases or decreases because of an event occurring after the impairment was recognised, the previously recognised impairment loss is increased or reduced by adjusting the allowance account.

Impairment of non-financial assets

The Scheme assesses at each reporting date whether there is an indication that an asset may be impaired. If any such indication exists, or when annual impairment testing for an asset is required, the Scheme makes an estimate of the asset's recoverable amount. An asset's recoverable amount is the higher of an asset's or cash-generating unit's fair value less costs of disposal and its value in use and is determined for an individual asset, unless the asset does not generate cash inflows that are largely independent of those from other assets or group of assets. Where the carrying amount of an asset exceeds its recoverable amount, the asset is considered impaired and is written down to its recoverable amount. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.
An assessment is made at each reporting date as to whether there is any indication that previously recognised impairment losses may no longer exist or may have decreased. If such indication exists, the Scheme makes an estimate of recoverable amount. A previously recognised impairment loss is reversed only if there has been a change in the estimates used to determine the asset's recoverable amount since the last impairment loss was recognised. Such reversal is recognised in the surplus or deficit.

1.14 **Investment income**

Interest is recognised on a time proportion basis, taking into account the principal outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme. Dividends are recognised when they become payable to the Scheme.

1.15 **Allocation of income and expenses**

Contribution income, claims incurred and net income/(expense) on risk transfer arrangements are directly allocated to benefit options. The remaining items are split based on contribution income on each option.

1.16 **Taxation**

In terms of section 10 (1) (d) of the Income Tax Act of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical Scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

1.17 **Relevant healthcare expenditure**

Relevant healthcare expenditure consists of net claims incurred and net income or expense from risk transfer arrangements.

1.18 **Operating lease payments - as lessee**

Operating lease payments are recognised as an expense in the statement of surplus or deficit on a straight line basis over the lease term.

1.19 **International Financial Reporting Standards issued, not yet effective**

New Standards, amendments and interpretations not yet effective, but relevant to the Scheme: (The Scheme does not plan to early adopt any of these standards.)

Standard	Subject	Effective date*
IFRS 9	Financial instruments : IFRS 9 (2009) retains but simplifies the mixed measurement model for financial assets and establishes two primary measurement categories: amortised cost and fair value. IFRS 9 (2010) adds the requirements related to the classification and measurement of financial liabilities, and derecognition of financial assets and liabilities. It also includes those paragraphs of IAS 39 dealing with how to measure fair value and accounting for derivatives embedded in a contract that contains a host that is not a financial asset.	01-Jan-18
IFRS 15	IFRS 15 Revenue from Contracts with Customers replaces IAS 11 Construction Contracts, IAS 18 Revenue and related interpretations. IFRS 15 specifies the accounting treatment for all revenue arising from contracts with customers. It applies to all entities that enter into contracts to provide goods or services to their customers, unless the contracts are in the scope of other IFRSs, such as IAS 17 Leases. The standard also provides a model for the measurement and recognition of gains and losses on the sale of certain non-financial assets, such as property or equipment. Extensive disclosures will be required, including disaggregation of total revenue; information about performance obligations; changes in contract asset and liability account balances between periods and key judgements and estimates.	01-Jan-18
IFRS 16	The IASB issued a new standard that requires lessees to recognise most leases on their balance sheets. Lessees will have a single accounting model for all leases, with certain exemptions. Lessor accounting is substantially unchanged. The new standard will be effective from 1 January 2019 with limited early application permitted.	01-Jan-19

* Annual periods beginning on or after the date stated, unless otherwise indicated

2 FURNITURE AND EQUIPMENT

	Office Furniture & Equipment R	Computer Equipment R	Total R
Year ended 31 December 2015			
Cost			
At the beginning of the year	480 120	228 546	708 666
Additions	-	-	-
At the end of the year	480 120	228 546	708 666
Accumulated depreciation			
At the beginning of the year	241 373	150 393	391 766
Depreciation charges	23 874	13 026	36 900
At the end of the year	265 247	163 419	428 666
Carrying amount at the end of the year	214 873	65 127	280 000
Year ended 31 December 2014			
Cost			
At the beginning of the year	476 132	228 546	704 678
Additions	3 988	-	3 988
At the end of the year	480 120	228 546	708 666
Accumulated depreciation			
At the beginning of the year	215 104	134 762	349 866
Depreciation charges	26 269	15 631	41 900
At the end of the year	241 373	150 393	391 766
Carrying amount at the end of the year	238 747	78 153	316 900

The Scheme currently only has furniture, office equipment and computer equipment.

		2015 R	2014 R
3	**TRADE AND OTHER RECEIVABLES**		
	Insurance receivables		
	Contributions outstanding	30 837 529	35 019 733
	Recoveries due from members and suppliers	3 239 973	7 828 743
	Savings plan account advances (refer note 6)	3 161 774	3 307 813
		37 239 276	46 156 289
	Less: Provision for impairment losses	(3 189 667)	(7 939 201)
		34 049 609	38 217 088
	Non insurance receivables		
	Other debtors	285 755	314 384
		34 335 364	38 531 472

The movement in the allowance for impairment during the year was as follows:

2015	Contribution debt	Savings debt	Member and supplier debt	Total
Balance as at 1 January	111 116	222 783	7 605 302	7 939 201
Amount recognised in surplus/deficit for the year (Note 15)	(53 262)	(84 526)	1 188 284	1 050 496
Additional provisions made in the year	-	-	1 478 784	1 478 784
Unused amounts reversed during the year	(53 262)	(84 526)	(290 500)	(428 288)
Written off during the year	-	-	(5 800 030)	(5 800 030)
Balance as at 31 December	57 854	138 257	2 993 556	3 189 667

2014	Contribution debt	Savings debt	Member and supplier debt	Total
Balance as at 1 January	157 000	222 707	6 521 771	6 901 478
Amount recognised in surplus/deficit for the year (Note 15)	(45 884)	76	1 083 531	1 037 723
Additional provisions made in the year	-	76	1 083 531	1 083 607
Unused amounts reversed during the year	(45 884)	-	-	(45 884)
Balance as at 31 December	111 116	222 783	7 605 302	7 939 201

At year-end the carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets. Debtors are non interest bearing, unsecured and contributions outstanding are payable within 3 days after year end.

		2015 R	2014 R
4	**INVESTMENTS HELD AT FAIR VALUE THROUGH SURPLUS OR DEFICIT**		
	Fair value at the beginning of the year	330 788 659	313 907 752
	Additions	226 391 788	23 183 000
	Disposals	(241 443 740)	(2 056 924)
	Unrealised fair value adjustment (refer note 17)	(15 342 063)	(4 245 169)
	Fair value at the end of the year	300 394 644	330 788 659
	The investments included above represent investments in:		
	Cash, Deposits and Money Market instruments	125 422 972	76 760 304
	Bills, Bonds and Securities	63 809 390	119 189 374
	Shares	111 162 282	134 838 981
		300 394 644	330 788 659

Included in the shares are derivative cash exposures and options hedge exposures linked to safex equity.

A register of investments is available for inspection at the registered office of the Scheme. The investment managers actively traded the underlying portfolios with reference to the market values of the underlying investments.

The overall weighted average effective return on the above investments was 5.3% (2014: 6.1%) for the year ended 31 December 2015.

		2015 R	2014 R
5	**CASH AND CASH EQUIVALENTS**		
	Call accounts and Money Market instruments	113 168 635	111 391 409
	Current accounts	52 452 227	23 613 372
		165 620 862	135 004 781

The weighted average effective interest rate on call accounts and money market instruments was 7.5% (2014: 6.6%).

Current accounts earn interest at floating rates based on daily rates.

At year-end the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

		2015 R	2014 R
6	**PERSONAL MEDICAL SAVINGS ACCOUNT TRUST MONIES**		
	The Scheme offers a savings plan on the Classic Option.		
	Balance of personal medical savings account (PMSA) trust liability at beginning of the year	57 857 547	48 329 360
	Less: Advances on savings plan accounts	(3 307 813)	(3 323 252)
	Net balance of PMSA trust liability at the beginning of the year	54 549 734	45 006 108
	Add:		
	PMSA contributions received or receivable (refer note 9)	105 724 299	104 468 400
	- for the current year	102 416 486	101 145 148
	- allocated to settle prior year advances	3 307 813	3 323 252
	Interest and other income earned on trust monies invested	4 266 946	3 314 876
	Less:		
	Transfers to other Schemes	(508 347)	(409 445)
	Repayments on death or resignation	(4 610 302)	(3 768 984)
	Claims paid on behalf of members (refer note 10)	(97 090 356)	(94 061 221)
	Add:		
	Advances on savings plan accounts included in trade and other receivables (refer note 3)	3 161 774	3 307 813
		65 493 748	57 857 547
	Funds held in trust	65 898 173	58 024 880
		65 898 173	58 024 880

Funds held in trust are re-balanced in the event that the savings plan liability is bigger than the funds held in trust. This ensures compliance with Circular 38 of 2011.

It is estimated that claims to be paid out of members' savings accounts in respect of claims incurred in 2015 but not recorded will amount to R3,520,916 (2014: R3,077,597) (refer note 8). As at year end, the carrying amount of the member's savings accounts were deemed to be equal to their fair values, which is the amount payable on demand. These amounts were not discounted due to the demand feature.

The PMSA trust liability represents funds held on behalf of members by the Scheme. The savings plan facility assists members in managing the cash flows for costs to be borne by them during the year, meeting provider service expenses not covered in the Scheme's approved benefits and meeting or self funding member co-payments for provider services rendered.

Unexpended savings at the year-end are carried forward to meet future expenses for which the members are responsible. The savings plan liability contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's personal medical savings account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and then enrols in another benefit option or Medical Scheme without a personal medical savings account or does not enrol in another Medical Scheme. In accordance with the rules of the Scheme, the bad debt risk of savings plans advances is underwritten by the Scheme.

Investment of personal medical savings account trust monies managed by the Scheme on behalf of its members:

	2015 R	2014 R
The investments comprises:		
- Money market trust fund	65 898 173	58 024 880
Total personal medical savings account trust monies invested	65 898 173	58 024 880

7 TRADE AND OTHER PAYABLES

	2015 R	2014 R
Insurance payables	3 792 537	7 601 967
Unallocated contributions	105 609	283 294
Credit balances in trade and other receivables	711 942	619 880
Amounts payable to suppliers	2 974 986	6 698 793
Non-insurance payables	3 137 581	3 091 385
Leave Pay	198 236	166 457
Accruals	660 180	621 868
Sundry trade and other payables	2 279 165	2 303 060
	6 930 118	10 693 352

The carrying amounts of trade and other payables approximate their fair values due to the short term maturities of these liabilities.

The amounts owed are interest free, unsecured and the terms of repayment are 30 days from invoice date.

8 OUTSTANDING CLAIMS PROVISION

	2015 R	2014 R
Provision for outstanding claims	47 881 387	48 868 628
Provision arising from liability adequacy test	-	-
	47 881 387	48 868 628

Analysis of movements in outstanding claims

Balance at beginning of year	48 868 628	43 885 847
Payments in respect of prior year	(49 254 482)	(44 302 385)
Under provision in prior year (refer note 10)	(385 854)	(416 538)
Increase in provision for the current year	48 267 241	49 285 166
Balance at end of year	47 881 387	48 868 628

Analysed as follows

Estimated gross claims	51 402 303	51 946 225
Less: Estimated recoveries from savings plan accounts	(3 520 916)	(3 077 597)
Balance at end of year	47 881 387	48 868 628

8 OUTSTANDING CLAIMS PROVISION (continued)

Basis for determination of the outstanding claims provision

The outstanding claims provision is a provision for the estimated cost of healthcare benefits that have occurred before the reporting date but have not been reported to the Scheme by that date. The provision is determined as accurately as possible based on a number of assumptions which are outlined below.

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in neutral estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out on a regular basis. There is more emphasis on current trends, and where in early years there is insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

The actual method or blend of methods used varies by category of claims and observed historical claims development. To the extent that the historical claims development method is used, we assume that the historical pattern will occur again in the future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include:

- changes in processes that affect the development or recording of claims paid and incurred (such as changes in claims submission mechanisms);
- changes in the composition of the membership of the Scheme;
- variations in the nature of claims(claim types); and
- random fluctuations.

Notified claims are assessed with due regard to the claim circumstances, category, anticipated development, expected seasonal fluctuations, and information available from managed care: management services. The provisions are best estimates based on the most recent information available. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the ultimate costs of the loss is difficult to estimate. The provision estimation difficulties also differ by category of claims (i.e. hospital (major medical benefit), chronic, and day-to-day) due to differences in the underlying insurance contract, claim complexity, the volume of claims, the individual severity of claims, determining the occurrence date of a claim, and reporting lags.

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding claims provision are the claim "run-off periods" for the most recent benefit years (split by discipline). The run-off factor is the expected percentage of claims paid out of total claims incurred in a specific month. This factor is then used to project the remainder of the outstanding claims relating to the specified service month. A "seasonality factor" is further incorporated into the calculation, also based on past claims experience. These assumptions have been used for assessing the outstanding claims provisions for the 2014 and 2015 benefit year.

8 OUTSTANDING CLAIMS PROVISION (continued)

Changes in assumptions

The table below outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables.

Where variables are considered to be immaterial, no impact has been assessed for insignificant changes to these variables. Particular variables may not be considered material at present. However, should the materiality level of an individual variable change, assessment of changes to that variable in the future may be required.

An analysis of sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the Scheme's estimation process. The Scheme believes that the liability for claims reported in the statement of financial position is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise. Consequently, if for example the estimates of the unreceived portion of claims costs for the year was between 3% - 5% inaccurate, the impact on the net surplus or deficit of the Scheme would be as follows:

Impact on reported profits due to changes in key variables

	Change in liability 2015 R	Change in liability 2014 R
3% Change in estimates	1 436 442	1 466 059
4% Change in estimates	1 915 255	1 954 745
5% Change in estimates	2 394 069	2 443 431

This analysis has been prepared for a change in a specified variable with other assumptions remaining constant. The change in liability also represents the absolute change in surplus or deficit for the period. These reasonably possible changes in key variables do not result in any changes directly in reserves.

The value of the claims incurred in 2016 which were paid subsequent to the year end until 18 March 2016 are detailed below:

	2015 R	2014 R
Outstanding claims provision	47 881 387	48 868 628
Portion of outstanding claims provision paid	(43 953 488)	(45 413 481)
Residual estimate of claims incurred but not paid	3 927 899	3 455 147

9 RISK CONTRIBUTION INCOME

Gross contributions	820 613 145	809 971 526
Less: Savings contributions (refer note 6)	(105 724 299)	(104 468 400)
Risk contribution income	714 888 846	705 503 126

		2015 R	2014 R
10	**NET CLAIMS INCURRED**		
	Claims incurred, excluding claims incurred in respect of risk transfer arrangements - current year claims	646 198 987	645 569 805
	Movement in outstanding claims provision	48 267 241	49 285 166
	- Under provision in prior year (refer note 8)	385 854	416 538
	- Adjustment for current year	47 881 387	48 868 628
		694 466 228	694 854 971
	Less:		
	- Claims paid from savings accounts (refer note 6)	(97 090 356)	(94 061 221)
	Claims incurred in respect of risk transfer arrangements:		
	Carecross Pty Ltd - current year claims (refer note 11)	76 421 358	74 438 231
	Total net claims incurred	673 797 230	675 231 981
11	**NET INCOME ON RISK TRANSFER ARRANGEMENT**		
	Carecross Pty Ltd		
	Recoveries under risk transfer arrangement	76 421 358	74 438 231
	Premiums paid in respect of risk transfer arrangement	(60 685 405)	(58 017 664)
	Net income on risk transfer arrangement	15 735 953	16 420 567

Carecross Pty Ltd provided basic primary care to the members on the Essential and Custom options during the year.

		2015 R	2014 R
12	**MANAGED CARE: MANAGEMENT SERVICES**		
	Momentum Medical Scheme Administrators Pty Ltd	14 426 092	13 931 581
	Pharmacy Benefit Management	2 210 876	2 216 985
	Dental Management Services	1 140 412	1 156 714
		17 777 380	17 305 280

Momentum Medical Scheme Administrators Pty Ltd provides managed care services to the Scheme. The Scheme also uses Mediscor which provides pharmacy benefit management and Dental Risk Company which provides dental management services.

	2015 R	2014 R
13 ADMINISTRATION EXPENSES		
Administrator's fees	47 388 074	46 673 616
Auditor's remuneration	867 808	767 108
- audit fees - current year	786 000	734 000
- audit fees - under-provision prior year	16 377	8 277
- other services	65 431	24 831
Annual general meeting costs	518 588	299 021
Audit committee fees	48 720	46 770
Building and maintenance	89 123	48 203
Computer expenses	227 665	261 000
Consultants fees	310 300	415 888
Debt collection fees	148 542	-
Depreciation	36 900	41 900
Fidelity and insurance	176 333	182 711
Legal costs	925 001	644 351
Principal Officer salary, benefits and expenses	1 983 555	1 878 885
Salary	1 616 414	1 506 917
Pension	205 889	192 600
Other benefits	55 511	57 192
Expenses	105 741	122 176
Printing, postage and stationery	69 007	72 708
Communication, education and marketing costs	2 923 270	4 140 169
Registrar's levies	812 152	770 475
Rent expense	491 659	439 004
Trustees fees and expenses	585 933	664 942
Telephone	114 010	108 669
Travel and accommodation	194 583	183 173
Staff costs	3 037 023	2 765 989
Salary	2 353 306	2 159 325
Medical	87 714	80 856
Pension	307 452	284 952
Other	288 551	240 856
Sundry expenses	261 908	239 746
	61 210 154	60 644 328
14 BROKER SERVICE FEES		
Broker service fees	3 299 964	4 484 212

	2015 R	2014 R
15 NET IMPAIRMENT LOSSES ON HEALTHCARE RECEIVABLES		
Outstanding member contributions	(53 262)	(45 884)
Movement in provision	(53 262)	(45 884)
Members' and service providers' portions	1 056 491	1 083 531
Movement in provision	1 188 284	1 083 531
Less: Recovery of amounts previously written off	(131 793)	-
Advances from savings plan accounts	(84 526)	76
Movement in provision	(84 526)	76
	918 703	1 037 723
16 INVESTMENT INCOME		
Investments held at fair value through surplus or deficit	15 643 781	17 461 731
Interest received	11 367 663	13 099 827
Dividends received	4 276 118	4 361 904
Cash and cash equivalents interest income	14 053 001	13 041 663
Current accounts and Money Market instruments	9 870 777	9 774 122
Savings investment	4 182 224	3 267 541
	29 696 782	30 503 394
16.1 INVESTMENT MANAGEMENT EXPENSES		
Investment consultants	464 983	438 650
Investment managers	2 274 955	2 439 360
	2 739 938	2 878 010
17 FAIR VALUE ADJUSTMENT		
Realised gains	17 114 803	5 186 623
Unrealised loss on remeasurement (refer note 4)	(15 342 063)	(4 245 169)
Net fair value adjustment for the year	1 772 740	941 454

The realised gains from trading arise from investment portfolios where shares and bonds are trading during the ordinary course of business.

18 CASH OUTFLOW FROM OPERATIONS BEFORE WORKING CAPITAL CHANGES		
Reconciliation of net surplus/(deficit) for the year to cash flows from operations before working capital changes		
Net surplus/(deficit) for the year	976 625	(11 464 369)
Adjustments for:		
- Investment income	(29 696 782)	(30 503 394)
- Investment management fees	2 739 938	2 878 010
- (Decrease)/increase in outstanding claims provision	(987 240)	4 982 781
- Unrealised fair value adjustment	15 342 063	4 245 169
- Depreciation	36 900	41 900
- Interest paid on members' savings accounts	4 266 946	3 314 876
Cash flows from operations before working capital changes	(7 321 550)	(26 505 027)

19 RELATED PARTY TRANSACTIONS

	2015 R	2014 R
Momentum Medical Scheme Administrators Pty Ltd (MMSA), a wholly owned subsidiary of MMI Group Ltd, as a third party administrator is deemed a related party, and received administration and managed care fees detailed as follows (refer notes 12 and 13):		
Administration fees	47 388 074	46 673 616
Managed care fees	14 426 092	13 931 581
	61 814 166	60 605 197
Amount owing to MMSA at year end	(1 096 191)	(4 885 424)

There are no credit terms in place, and amounts are settled on presentation of the invoice.

Carecross Holdings was acquired by the MMI group in 2014. Carecross Health Pty Ltd provides basic primary care to the members on the Essential and Custom options, and chronic medication and specialist out of hospital treatment to members on the Custom option. These services form part of a risk transfer arrangement with the Scheme (refer note 11)

Premiums paid in respect of risk transfer arrangement	60 685 405	58 017 664

Contributions billed to, contributions received from, and claims paid in respect of the Board of Trustees and the Principal Officer of the Scheme during the year, were done so in accordance with the rules of the Scheme and the provisions of the Medical Schemes Act. Accordingly, all Board of Trustees members and the Principal Officer were treated in the same manner by the Scheme as would any member have been.

Net contribution income received from the Board of Trustees and Principal Officer for the year was R513,751 (2014: R428,096). Net claims paid were R540,389 (2014: R173,198). The Principal officer's salary expense was R1,983,555 (2014: R1,878,885). Refer Note 13 for a breakdown of the Principal Officer's salary and expenses. For a breakdown of the Board of Trustees' fees and expenses, please refer Note 25.

20 MINIMUM LEASE PAYMENTS

	2015 R	2014 R
Rental expense		
1 year	373 407	442 326
2-5 years	74 445	500 730
	447 852	943 056

Minimum lease payments represent contractual lease payments for leasing of corporate offices in Randburg and office equipment.

The corporate office lease terminates on 31 December 2016 and has a 6% escalation rate. The office equipment lease terminates in August 2016 and July 2018 and they have escalation rates of 9% and 0% respectively.

21 INSURANCE RISK MANAGEMENT

Risk management objectives and policies for mitigating medical insurance risk

The primary medical insurance activity carried out by the Scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. These risks relate to the health of the Scheme members. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract. The Scheme also has exposure to market risk through its medical insurance and investment activities.

The Scheme manages its medical insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of risk transfer arrangements as well as the monitoring of emerging issues.

The Scheme uses several methods to assess and monitor medical insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of medical insurance contracts. The principal risk is that the frequency and severity of claims is greater than expected.

The Scheme's strategy seeks to ensure a balanced portfolio and is based on a large portfolio of similar risks over a number of years and, as such, it is believed that this reduces the variability of the outcome. The strategy is set out in the annual business plan, which specifies the benefits to be provided by each option, the preferred target market and demographic split thereof.

All the contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contract at renewal. Management information including contribution income and claims ratios by option, target market and demographic split, is reviewed monthly. There is also a program that regularly reviews contractual premium and benefit data to ensure adherence to the Scheme's objectives.

Medical insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated.

21 INSURANCE RISK MANAGEMENT (continued)

The Scheme cedes medical insurance risk to limit exposure to underwriting losses under various agreements that cover individual risks and defined blocks of risk, on a co-insurance, yearly renewable term. These risk transfer arrangements spread the risk and minimise the effect of losses. The amount of each risk retained depends on the Scheme's evaluation of the specific risk, subject in certain circumstances, to maximum limits based on characteristics of coverage. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to Scheme members on various benefit options, as and when required by the members. The Scheme does, however, remain liable to its members with respect to ceded medical insurance if any capitation provider fails to meet the obligations it assumes. When selecting a capitation provider the Scheme considers its stability from public rating information and from internal investigations.

The following table summarises the concentration of medical insurance risk on a beneficiary level, with reference to the net carrying amount of the medical insurance claims incurred in respect of the 2014 and 2015 financial years, by age group and in relation to the type of risk covered or benefits provided. Where appropriate prescribed minimum benefits (PMB) and non-PMB claims have been split.

	Hospital (major medical)		Chronic		Day to day	Total
	PMB	Non PMB	PMB	Non PMB		
2015	R'000	R'000	R'000	R'000	R'000	R'000
Age grouping (in years)						
< 26	38 255	19 408	1 552	767	3 935	63 917
26 - 35	36 774	12 085	1 453	130	1 276	51 718
36 - 50	60 567	23 556	7 418	597	4 795	96 933
51 - 65	92 425	27 316	14 358	1 173	8 342	143 614
> 65	136 758	31 452	16 865	1 570	8 152	194 797
Total amount	364 779	113 817	41 646	4 237	26 500	550 979

	Hospital (major medical)		Chronic		Day to day	Total
	PMB	Non PMB	PMB	Non PMB		
2014	R'000	R'000	R'000	R'000	R'000	R'000
Age grouping (in years)						
< 26	35 478	20 343	1 585	629	4 443	62 478
26 - 35	32 853	13 727	1 427	159	1 450	49 616
36 - 50	66 936	23 145	6 866	610	5 699	103 256
51 - 65	90 778	24 912	14 770	1 346	8 980	140 786
> 65	141 181	30 935	15 580	1 543	7 987	197 226
Total amount	367 226	113 062	40 228	4 287	28 559	553 362

21 INSURANCE RISK MANAGEMENT (continued)

Hospital (major medical) benefits cover all costs incurred by members whilst they are in hospital receiving preauthorised treatment for certain medical conditions. Chronic benefits cover the cost of certain prescribed medicines consumed by members for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma. Day-to-day benefits cover the cost of all out of hospital medical attention, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines.

Claims development

Claims development tables are not presented since the uncertainty regarding the amount and timing of claim payments is typically resolved within one year.

22 FINANCIAL RISK MANAGEMENT

The Scheme's activities expose it to a variety of financial risks, including the effects of changes in the credit risk, liquidity risk and market risk. The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments that the Scheme holds to meet its obligations to its members.

Risk management and investment decisions are carried out by the administrators and investment managers, under the guidance and policies approved by the Board of Trustees.

The Scheme's risk management policies are established to identify and analyse the risks faced by the Scheme, to set appropriate risk limits and controls, and to monitor risks and adherence to limits. Risk management policies and systems are reviewed regularly to reflect changes in market conditions and the Scheme's activities. The Scheme, through its training and management standards and procedures, aims to develop a disciplined and constructive control environment in which all employees understand their roles and obligations.

The Scheme's Audit Committee oversees how management monitors compliance with the Scheme's risk management policies and procedures and reviews the adequacy of the risk management framework in relation to the risks faced by the Scheme. The Scheme's Audit Committee is assisted in its oversight role by the Internal Audit division. Internal Audit undertakes both regular and ad-hoc reviews of risk management controls and procedures, the results of which are reported to the Audit Committee.

22 FINANCIAL RISK MANAGEMENT (continued)

Market Risk

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. Market prices comprise interest rate risk, currency risk, and equity risk. There is no exposure to currency risk.

Interest Rate Risk

Interest rate risk is the exposure that the Scheme has to changes in interest rates. The main exposure to the Scheme would be a reduction in interest income on investments if interest rates were to decrease. In order to reduce the impact of any potential interest rate changes, the Scheme holds a diversified portfolio of investments in the short term.

If interest rates increased or decreased by 1.5% (2014 : 1.5%), assuming all other variables remain constant, and the recent past is predictive of the future, the impact on return on investment and the resulting impact on the surplus of the Scheme is as follows:

	2015 R'000	2014 R'000
Effect on investment income	4 366	3 176

The table below summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments in interest bearing instruments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

	Up to 1 month R'000	1 - 12 months R'000	Total R'000
As at 31 December 2015			
Investments held at fair value through surplus or deficit	-	125 423	125 423
Cash and cash equivalents	52 452	113 169	165 621
Total	52 452	238 592	291 044
As at 31 December 2014			
Investments held at fair value through surplus or deficit	-	76 760	76 760
Cash and cash equivalents	23 613	111 392	135 005
	23 613	188 152	211 765

Equity Risk

Equity risk is the risk that the value of a financial instrument will fluctuate as a result of changes in the market place.

Equities are reflected at market values, which are susceptible to fluctuations. The Scheme manages it's equity risk by employing the following procedures:
- mandating a specialist scheme manager to invest in equities, where there is an active market and where access is gained to a broad spectrum of financial information relating to the companies invested in;
- diversifying across many securities to reduce risk. Diversification is guided by the Medical Schemes Act; and
- considering the risk-reward profile of holding equities and bearing the risk in order to obtain higher expected returns on assets.

22 FINANCIAL RISK MANAGEMENT (continued)

Equity Risk (continued)

Should the South African equities market change by 5.0% (2014 : 5.0%), assuming all other variables remain constant, and the recent past is predictive of the future, the impact on surplus or deficit would be as follows:

	2015 R'000	2014 R'000
Equity	5 835	6 573

Credit Risk

Credit risk is the risk of financial loss to the Scheme if a customer or counterparty to a financial instrument fails to meet its contractual obligations. The Scheme's principal financial assets are cash and cash equivalents, trade and other receivables and investments.

The Scheme has no significant concentration of credit risk, with exposure spread over a large number of counterparties and members

Trade and other receivables

The Scheme's credit risk is primarily attributable to trade and other receivables. The amounts presented in the statement of financial position are net of allowances for possible impairment losses, estimated by the Scheme's management based on prior experience and the current economic environment.

The maximum exposure to credit risk at the reporting date is the carrying value of each class of financial assets disclosed in Note 3.

The Scheme assesses the credit quality of trade and receivables based on successful recovery of non-impaired receivables. Based on the successful recoveries the Scheme views the quality of its trade and other receivables as high. Consequently no additional disclosure of credit quality is provided.

	2015 R'000	2014 R'000
Fully performing	34 178	38 418
Past due but not impaired	157	113
Past due and impaired	3 190	7 939
	37 525	46 470
Provision for impairment of trade and other receivables	(3 190)	(7 939)
Trade and other receivables (refer note 3)	34 335	38 531

For detailed explanation of impairment procedures for the Scheme, refer Note 1.13.
The amount in the past due but not impaired category has not been aged since it all related to balances receivable up to 60 days.

The credit risk on liquid funds is limited because the counterparties are banks with high credit ratings assigned by international credit rating agencies.

22 FINANCIAL RISK MANAGEMENT (continued)

Liquid Funds

	2015 R'000	2014 R'000
ABSA Bank	11 262	14 651
African Bank	5 103	4 725
First National Bank *	28 366	18 803
Land and Agriculture Bank	-	10 138
Investec Bank Limited	5 047	-
Nedbank	20 209	25 303
Standard Bank *	85 567	46 298
Southchester Conduit (RF) Limited	-	5 002
Transnet Limited	10 067	10 084
Total call accounts current accounts and money market instruments (Note 5)	165 621	135 004

* - Includes the current account

Liquidity risk

Prudent liquidity risk management implies maintaining sufficient cash and cash equivalents by monitoring the availability of funding through liquid-holding cash positions with various financial institutions. This ensures that the Scheme has the ability to fund its day-to-day operations.

The table below analyses the assets and liabilities of the Scheme into relevant maturity groupings based on the remaining period at reporting date to the contractual maturity date:

	On demand R'000	Within 3 months R'000	3 - 12 months R'000	Over 1 year R'000	Total R'000
As at 31 December 2015					
Assets	86 630	113 326	-	-	199 956
Trade and other receivables	34 178	157	-	-	34 335
Cash and cash equivalents	52 452	113 169	-	-	165 621
Liabilities	41 552	9 188	66 427	-	117 167
Savings plan liability	2 791	202	62 500	-	65 493
Insurance payables	3 793	-	-	-	3 793
Outstanding claims provision	34 968	8 986	3 927	-	47 881
Net positive liquidity	45 078	104 138	(66 427)	-	82 789
As at 31 December 2014					
Assets	62 031	111 505	-	-	173 536
Trade and other receivables	38 418	113	-	-	38 531
Cash and cash equivalents	23 613	111 392	-	-	135 005
Liabilities	45 574	7 520	61 233	-	114 327
Savings plan liability	2 479	444	54 933	-	57 856
Insurance payables	7 602	-	-	-	7 602
Outstanding claims provision	35 493	7 076	6 300	-	48 869
Net positive liquidity	16 457	103 985	(61 233)	-	59 209

22 FINANCIAL RISK MANAGEMENT (continued)

Fair value estimation

At year-end the carrying amounts approximate their fair values due to the short-term maturities of these assets and liabilities.

Fair value hierarchy

The Scheme uses the following hierarchy for determining and disclosing the fair value of financial instruments by valuation technique:

Level 1 Quoted (unadjusted) prices in active markets for identical assets or liabilities.
Level 2 Other techniques for which all inputs which have a significant effect on the recorded fair values are observable, either directly or indirectly.
Level 3 Techniques which use inputs which have a significant effect on the recorded fair value that are not based on observable market data.

The fair value of publicly traded financial instruments held as investments held at fair value through surplus or deficit, is based on quoted market prices at the reporting date. Instruments classified as held at fair value through surplus or deficit in the statement of financial position are held at fair value. All financial assets held at fair value are level 1 in the fair value hierarchy.

	2015 R'000	2014 R'000
Financial Assets		
Level 1		
Investments held at fair value through surplus or deficit		
Cash and Deposits	125 423	76 760
Bills, Bonds and Securities	63 809	119 189
Shares	111 162	134 839
	300 394	330 788

Capital Adequacy Risk

This represents the risk that there are insufficient reserves to provide for adverse variations on actual and future experience. The Scheme defines its capital as accumulated funds as detailed in the statement of changes in funds and reserves. The Scheme manages its capital to ensure that it will be able to continue as a going concern as well as meet the solvency ratio of 25%, as regulated by the Medical Schemes Act of 1998. The Scheme had R446 million (2014: R445 million) of accumulated funds at 31 December 2015, which translated to an accumulated funds ratio of 54.4% (2014: 53.5%).

23 FIDELITY COVER

The Scheme participated in fidelity insurance and professional indemnity cover provided by Marsh Pty Ltd amounting to R10 million.

24 NON-COMPLIANCE WITH MEDICAL SCHEMES ACT 131 of 1998

The following areas of non-compliance of the Medical Schemes Act 131, 1998 were identified during the course of the year, none of which were, in the opinion of the Board of Trustees of a significant nature:

1. Benefit options in loss making position

Nature and impact of non-compliance
In terms of the Medical Schemes Act and specifically Section 33 (2) it is a requirement that each individual benefit option should be financially sound.

The Scheme has benefit options that are in a loss making position at a net healthcare result level at year end and are therefore indirectly subsidised by the other benefit options. The contravention of the Act may be to the detriment of some of the members on the Scheme, but this situation is common in the industry.

Causes of failure

The affected benefit options risk profiles are worse than the average of the total Scheme, resulting in a worse than anticipated financial position.

Corrective action

The Scheme informs the Council for Medical Schemes (CMS) of these challenges. The scheme is committed to rectify the situation through marketing and benefit design.

2. Contributions received within 3 days of becoming due

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 26(7) it is a requirement that contributions should be received within three days of becoming due.

During the year under review there were instances where premiums were not received within the three days as prescribed by the Act.

Causes of failure

The reason for this is due to the inherent nature of the business.

Corrective action

The Scheme through its administrators has implemented adequate credit control policies and procedures to minimise the risk of non recoverability. The risk is considered insignificant by the Board of Trustees.

3. Claims paid within 30 days of receipt

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 59(2) it is a requirement that claims should be paid within 30 days of receipt thereof. Instances were noted where claims were paid after 30 days of receipt.

Causes of failure

Claims are generally paid within this 30 day requirement, but due to certain procedures such as clinical auditing, there are exceptions where certain claims are paid after 30 days of date of receipt.

Corrective action

The Scheme has acknowledged that since it only applies to a few claims where such procedures are necessary to validate claims, this risk is considered insignificant.

4. Limitation of assets

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Regulation 35(8)(c), a medical scheme shall not invest any of its assets in the business of or grant loans to any administrator. As at the 31 December 2015, the Scheme had investments in administrators.

Causes of failure

The Scheme appointed reputable asset managers who are managing the investment portfolios to the best interest of the Scheme. The Scheme does not influence the asset manager on the selection of shares or instruments in the portfolio which sometimes includes shares listed on the JSE of insurance companies with an interest in an administrator of a medical scheme.

Corrective action

The Scheme obtained an exemption from the provision of Regulation 35(8)(c) from CMS and therefore does not consider this a non-compliance.

5. Prescribed Minimum Benefits

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Regulations 8(1) and 10(6), Prescribed Minimum Benefits must be paid in full and cannot be paid from a member's savings account. During sample testing instances were noted where Prescribed Minimum Benefits were not paid in full and were paid from member's savings accounts.

Causes of failure

The administration system has been set up to settle all PMB claims according to Scheme rules. It is acknowledged that identifying a claim as a PMB is a complex issue given the lack of a workable industry (ICD10) coding system. Many PMB's cannot initially be correctly identified as PMB's based on the ICD10 codes provided.

Corrective action

The Scheme and administrator continue to monitor the payment of PMB claims in order to ensure the best outcome for the member and the Scheme. Adjustments are made when additional medical evidence is provided as confirmation of a PMB.

6. Fees payable to brokers

Nature and impact of non-compliance

In terms of the Medical Schemes Act and specifically Section 65 and Regulation 28 , a medical scheme is prohibited to compensate brokers for the period during which they are suspended. Thethani was paid from January to March 2015, whilst they were suspended due to their deaccreditation.

Causes of failure

The Scheme was unaware of the fact that the brokers at Thethani were unaccredited, hence were suspended from performing broker services and all payments to Thethani were made as normal by the Scheme. The Scheme members were still being serviced during this period.

Corrective action

The Scheme has post year end recovered all payments made to Thethani, while being unaccredited. Thethani reapplied for accreditation and has been subsequently accredited.

25 TRUSTEE EXPENSES

2015

	Travel	Fees for meetings attendance	Total
	R	R	R
B Canning	81 997	65 320	147 317
D Simpson	-	23 760	23 760
E Kubeka	-	21 780	21 780
H Lombard	34 377	43 560	77 937
R Strydom	-	30 100	30 100
E Phillips	20 824	19 800	40 624
J Mthimunye	6 650	25 740	32 390
A van der Rheede	23 228	21 780	45 008
J Olivier	-	17 030	17 030
M Roberts	22 077	15 050	37 127
J Schoeman	-	17 820	17 820
W Schroeder	-	47 520	47 520
R Sibiya	-	25 740	25 740
S Tsiane	-	21 780	21 780
	189 153	396 780	585 933

2014

	Travel	Fees for meetings attendance	Total
	R	R	R
B Canning	44 484	49 790	94 274
E Kubeka	-	34 600	34 600
H Lombard	42 682	38 480	81 162
J Mthimunye	7 672	38 690	46 362
A van der Rheede	39 501	34 730	74 231
J Olivier	-	34 730	34 730
M Roberts	65 333	49 580	114 913
J Schoeman	-	51 900	51 900
W Schroeder	-	40 540	40 540
R Sibiya	-	40 670	40 670
S Tsiane	-	51 560	51 560
	199 672	465 270	664 942

Trustees may serve on more than one operational committee to ensure representation in operational decision-making. When necessary, the Board appoints additional ad hoc committees to evaluate specific strategic issues.

26 RECLASSIFICATION OF COMPARATIVE AMOUNTS

In terms of Circular 56 of 2015 by the Council for Medical Schemes, all accredited managed healthcare services are being included as part of healthcare expenditure as they directly impact on the delivery of the cost effective and appropriate healthcare benefits to beneficiaries of medical schemes. The total amounts for managed care are thus in the current year included in relevant healthcare expenditure, instead of non healthcare costs. The effect of these current year reclassifications on the comparative amounts are summarised below:

Statement of Comprehensive Income

	2014
Prior year non healthcare expenditure before reclassification	83 471 543
Reclassification to relevant healthcare expenditure	(17 305 280)
Prior year non healthcare costs after reclassification	66 166 263
Prior year relevant healthcare expenditure before reclassification	658 811 414
Reclassification from non healthcare expenditure	17 305 280
Prior year relevant healthcare expenditure after reclassification	676 116 694

There were no effects of the above resclassification on the statement of financial position and the statement of cash flows.

27 EVENTS AFTER REPORTING DATE

There are no events or circumstances arising since reporting date and the date of the approval of these annual financial statements that materially affects the presentation of the annual financial statements.

28 SURPLUS/(DEFICIT) PER BENEFIT OPTION 2015

2015	ESSENTIAL OPTION R	CUSTOM OPTION R	HOSPICARE OPTION R	CLASSIC OPTION R	OPTIMUM OPTION R	TOTAL SCHEME R
Risk contributions	28 351 056	153 064 926	22 259 780	379 650 976	131 562 108	714 888 846
Relevant healthcare expenditure	(17 810 441)	(133 576 399)	(27 895 346)	(366 589 423)	(129 967 048)	(675 838 657)
Net claims incurred	(18 228 807)	(142 885 717)	(27 384 187)	(357 233 917)	(128 064 602)	(673 797 230)
Managed care: management services	(1 339 823)	(4 668 447)	(511 158)	(9 355 506)	(1 902 446)	(17 777 380)
Net income on risk transfer arrangements	1 758 189	13 977 764	-	-	-	15 735 953
Risk transfer arrangement expenses	(15 503 333)	(45 182 072)	-	-	-	(60 685 405)
Recoveries from risk transfer arrangements	17 261 522	59 159 836	-	-	-	76 421 358
Gross healthcare result	10 540 615	19 488 527	(5 635 566)	13 061 553	1 595 060	39 050 189
Administration expenses	(3 574 237)	(15 353 241)	(2 133 238)	(32 522 337)	(7 627 101)	(61 210 154)
Broker service fees	(520 724)	(1 435 945)	(54 169)	(1 238 942)	(50 184)	(3 299 964)
Net impairment losses on healthcare receivables	(27 625)	(268 084)	(28 246)	(497 339)	(97 409)	(918 703)
Net healthcare result	6 418 029	2 431 257	(7 851 219)	(21 197 065)	(6 179 634)	(26 378 632)
Other income	1 213 558	6 388 738	950 287	20 160 361	5 649 197	34 362 141
Other expenditure	(108 706)	(577 818)	(86 150)	(5 723 456)	(510 754)	(7 006 884)
Net surplus/deficit for the year	7 522 881	8 242 177	(6 987 082)	(6 760 160)	(1 041 191)	976 625
Number of members	4 286	8 694	916	9 742	1 514	25 152

28 SURPLUS/(DEFICIT) PER BENEFIT OPTION 2014

2014	ESSENTIAL OPTION R	CUSTOM OPTION R	HOSPICARE OPTION R	CLASSIC OPTION R	OPTIMUM OPTION R	TOTAL SCHEME R
Risk contributions	28 140 166	138 770 785	22 401 997	375 377 110	140 813 068	705 503 126
Relevant healthcare expenditure	(17 959 538)	(122 006 748)	(30 414 264)	(375 304 919)	(130 431 225)	(676 116 694)
Net claims incurred	(19 110 948)	(131 738 004)	(29 825 037)	(366 177 832)	(128 380 160)	(675 231 981)
Managed care: management services	(1 202 745)	(4 335 156)	(589 227)	(9 127 087)	(2 051 065)	(17 305 280)
Net income on risk transfer arrangements	2 354 155	14 066 412	-	-	-	16 420 567
Risk transfer arrangement expenses	(15 905 027)	(42 112 637)	-	-	-	(58 017 664)
Recoveries from risk transfer arrangements	18 259 182	56 179 049	-	-	-	74 438 231
Gross healthcare result	10 180 628	16 764 037	(8 012 267)	72 191	10 381 843	29 386 432
Administration expenses	(3 756 462)	(13 923 535)	(2 461 304)	(32 194 299)	(8 308 728)	(60 644 328)
Broker service fees	(571 824)	(1 618 503)	(96 208)	(1 938 633)	(259 044)	(4 484 212)
Net impairment losses on healthcare receivables	(15 896)	(89 064)	(22 837)	(772 882)	(137 044)	(1 037 723)
Net healthcare result	5 836 446	1 132 935	(10 592 616)	(34 833 623)	1 677 027	(36 779 831)
Other income	1 111 387	5 414 074	894 353	18 332 806	5 755 728	31 508 348
Other expenditure	(118 629)	(558 469)	(91 855)	(4 843 935)	(579 998)	(6 192 886)
Net surplus/deficit for the year	6 829 204	5 988 540	(9 790 118)	(21 344 752)	6 852 757	(11 464 369)
Number of members	4 696	8 636	1 056	10 185	1 693	26 266