MOTO HEALTH CARE

REGISTRATION NUMBER: 1600

SUMMARISED ANNUAL FINANCIAL STATEMENTS

31 DECEMBER 2016

MOTO HEALTH CARE

SUMMARISED ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2016

The reports and statements set out below comprise the summarised annual financial statements and report of the Board of Trustees presented to members. The full set of audited annual financial statements approved on the 12th of April 2017 is available on the Scheme's website (www.motohealthcare.org.za).

Contents	**Pages**

MOTO HEALTH CARE

REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2016

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 5 to the summarised 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	
R Strydom	
E Philips	
J Mthimunye	Appointed 26 October 2016
J Schoeman	Appointed 26 October 2016

PRINCIPAL OFFICER

Mr DFA van Tonder
279 Kent Avenue
Randburg
2125

PO Box 3882
Randburg
2125

REGISTERED OFFICE AND POSTAL ADDRESS OF THE SCHEME

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

ADMINISTRATOR

MMI Health Pty Ltd (Previously known as 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	PO 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 2016 was 51.6% (2015: 54.4%).

REVIEW OF THE YEAR'S ACTIVITIES

The results of the Scheme are set out in the attached summarised 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:

	2016 R'000	2015 R'000
Total members' funds per statement of financial position	434 880	446 224
Less: Cumulative unrealised net gains on re-measurement to fair value of financial instruments	-	-
Accumulated funds per Regulation 29	434 880	446 224
Gross contributions	843 399	820 613
Solvency ratio	51.6%	54.4%

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

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 7 to the summarised 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 2016

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	6	6		
H Lombard	6	6		
D Simpson	6	6	4	3
R Strydom	6	6	4	4
E Philips	6	6		
J Mthimunye	1	1		
J Schoeman	1	0		
W Schroeder	6	6		
Independent members				
I Catt			4	4
J Kotze			4	4
G Franck*			3	3
M Mafojane			4	4

* - resigned in December 2016
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. During 2016, the audit committee was further mandated to include risk review as part of its duties, thereby forming an audit and risk committee. At year end the committee consisted of five 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 four 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)
J Kotze (Independent)
M Mafojane (Independent)
D Simpson (Trustee)
R Strydom (Trustee)

MOTO HEALTH CARE

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2016

OPERATIONAL STATISTICS 2016

	2016					
	Essential Option	Custom Option	Hospicare Option	Classic Option	Optimum Option	Total Scheme
Number of members at the end of the accounting period	3 968	8 406	826	9 256	1 352	23 808
Number of beneficiaries at the end of the accounting period	8 481	18 825	1 420	20 291	2 678	51 695
Average number of members for the accounting period	4 081	8 547	838	9 557	1 395	24 418
Average number of beneficiaries for the accounting period	8 722	19 136	1 443	21 011	2 783	53 095
Average net contribution per beneficiary per month (pbpm)	R255	R704	R1 270	R1 572	R3 793	R1 151
Pensioner ratio (beneficiaries age > 65)	0.6%	4.6%	40.8%	15.4%	28.5%	10.4%
Average age per beneficiary	29.64	29.68	51.95	39.55	49.62	34.31
Relevant healthcare expenditure per average beneficiary	R2 017	R7 516	R18 675	R18 725	R43 082	R13 216
Non healthcare expenditure per average beneficiary	R460	R949	R1 536	R1 724	R2 740	R1 285
Average accumulated funds per member at the end of the accounting period #						R18 266
Dependants per member at the end of the accounting period	1.14	1.24	0.72	1.19	0.98	1.17
Return on investments as a % of investments #						5.9%
Non healthcare expenditure as a percentage of gross contributions	15%	11%	10%	7%	6%	8%
Relevant healthcare expenditure as a percentage of risk contributions	66%	89%	123%	99%	95%	96%

- ratio not presented per policy

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2016

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	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

ACTUARIAL SERVICES

The Scheme's actuaries are contracted to assist 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 2016, 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.

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2016

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 2016, 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.

REPORT OF THE BOARD OF TRUSTEES (continued)
for the year ended 31 December 2016

LITIGATION

Outstanding Appeal process: Three former Board members who had to vacate their positions on the Board due to their term of office expiring and because they are not members of the Scheme lodged complaints against the Scheme with the Council for Medical Schemes. The Registrar ruled against these former Board members and so did the Appeal Committee after they lodged an appeal. They have further appealed against that Ruling and the case has not yet appeared before the Appeal Board.

There was unresolved litigation in progress as at 31 December 2016 against the liquidated Calabash Health Solutions Pty Ltd, which has been ongoing since 2007. The Scheme is attempting to recover some funds in dispute from Calabash as a result of a past capitation agreement with the Scheme. 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 3 for further details.

GOING CONCERN

The Board of Trustees still believes that the Scheme is a going concern and the summarised annual financial statements have been prepared on this basis.

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 2016

The Board of Trustees is responsible for the preparation, integrity and fair presentation of the summarised annual financial statements of Moto Health Care. The summarised annual financial statements presented on pages 15 to 27 have been extracted from the audited annual financial statements as approved on the 12th of April 2017.

The Board of Trustees consider that in preparing the summarised 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 summarised 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 summarised financial statements. The Board's opinion is supported by the audit committee.

The going concern basis has been adopted in preparing the summarised 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 summarised annual financial statements support the viability of the Scheme.

The Board of Trustees is satisfied that the information contained in the summarised 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 summarised annual financial statements.

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

The summarised annual financial statements were approved by the Board of Trustees on 5 May 2017 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 2016

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 summarised 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, which is performed by KPMG, 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 audited annual financial statements, the main risks identified by this process as at 31 December 2016 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 and labour reductions by Employer members

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 2016

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

5 May 2017

INDEPENDENT AUDITOR'S REPORT ON SUMMARISED FINANCIAL STATEMENTS

Report on the Summarised Financial Statements

Opinion

The summarised financial statements, as set out on pages 15 to 27, which comprise the summarised statement of financial position as at 31 December 2016, the summarised statement of comprehensive income, the summarised statement of changes in funds and reserves and the summarised cash flow statement for the year then ended, and related notes, are derived from the audited financial statements of Moto Health Care for the year ended 31 December 2016.

In our opinion, the accompanying summarised financial statements are consistent, in all material respects, with the audited financial statements, in accordance with the content and disclosure requirements of Circular 6 of 2013 issued by the Council for Medical Schemes.

Summarised Financial Statements

The summarised financial statements do not contain all the disclosures required by International Financial Reporting Standards and the Medical Schemes Act of South Africa. Reading the summarised financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements and the auditor's report thereon. The summarised financial statements and audited financial statements do not reflect the effects of events that occurred subsequent to the date of our report on the audited financial statements.

The Audited Financial Statements and Our Report Thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated 12 April 2017.

Trustees' Responsibility for the Summarised Financial Statements

The trustees are responsible for the preparation of the summarised financial statements in accordance with the content and disclosure requirements of Circular 6 of 2013 issued by the Council for Medical Schemes as set out on page 11 of the summarised financial statements.

Auditor's Responsibility

Our responsibility is to express an opinion on whether the summarised financial statements are consistent, in all material respects, with the audited financial statements based on our procedures, which were conducted in accordance International Standards on Auditing (ISA) 810 (Revised), Engagements to Report on Summary Financial Statements.

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

5 May 2017

MOTO HEALTH CARE

SUMMARISED STATEMENT OF FINANCIAL POSITION
at 31 December 2016

	Notes	2016 R	2015 R
ASSETS			
Non-current assets		304 800	280 000
Furniture and equipment		304 800	280 000
Current assets		569 239 784	566 249 043
Trade and other receivables		38 899 643	34 335 364
Investments held at fair value through surplus or deficit		313 348 460	300 394 644
Cash and cash equivalents		142 441 816	165 620 862
Personal medical savings trust investments	2	74 549 865	65 898 173
Total assets		569 544 584	566 529 043
FUNDS AND LIABILITIES			
Accumulated Funds		434 880 185	446 223 790
Current liabilities		134 664 399	120 305 253
Personal medical savings account trust monies	2	73 997 829	65 493 748
Trade and other payables		11 371 035	6 930 118
Outstanding claims provision	3	49 295 535	47 881 387
Total funds and liabilities		569 544 584	566 529 043

MOTO HEALTH CARE

SUMMARISED STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2016

	Notes	2016 R	2015 R
Risk contribution income	4	733 482 373	714 888 846
Relevant healthcare expenditure		(701 701 732)	(675 838 657)
Net claims incurred		(698 197 063)	(673 797 230)
Risk claims incurred		(699 623 991)	(674 872 172)
Third party claim recoveries		1 426 928	1 074 942
Managed care: management services		(17 910 592)	(17 777 380)
Net income on risk transfer arrangement	5	14 405 923	15 735 953
Risk transfer arrangement expenses		(61 564 069)	(60 685 405)
Claim recoveries from risk transfer arrangement		75 969 992	76 421 358
Gross healthcare result		31 780 641	39 050 189
Administration expenses		(61 818 439)	(61 210 154)
Broker service fees		(3 967 020)	(3 299 964)
Net impairment losses on healthcare receivables		(2 438 560)	(918 703)
Net healthcare result		(36 443 378)	(26 378 632)
Other income		33 383 335	34 362 141
Sundry income		741 826	2 892 619
Investment income		34 892 585	29 696 782
Fair value adjustment	6	(2 251 076)	1 772 740
Other expenditure		(8 283 562)	(7 006 884)
Investment management fees		(2 738 879)	(2 739 938)
Interest paid on savings balances	2	(5 544 683)	(4 266 946)
Net (deficit)/surplus for the year	11	(11 343 605)	976 625
Other comprehensive income		-	-
Total comprehensive (deficit)/surplus for the year		**(11 343 605)**	**976 625**
Solvency ratio		**51.6%**	**54.4%**

MOTO HEALTH CARE

SUMMARISED STATEMENT OF CHANGES IN FUNDS AND RESERVES
for the year ended 31 December 2016

	Accumulated funds R
Balance as at 1 January 2015	445 247 165
Total comprehensive surplus for the year	976 625
Balance as at 31 December 2015	446 223 790
Total comprehensive deficit for the year	(11 343 605)
Balance as at 31 December 2016	434 880 185

MOTO HEALTH CARE

SUMMARISED STATEMENT OF CASH FLOWS
for the year ended 31 December 2016

	Note	2016 R	2015 R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flow from operations before working capital changes		(34 028 681)	(7 321 550)
Working capital changes			
- (Increase)/decrease in trade and other receivables		(4 564 279)	4 196 108
- Increase in savings plan net asset		(147 611)	(237 092)
- Increase/(decrease) in trade and other payables		4 440 917	(3 763 235)
Cash flows from operations		(34 299 654)	(7 125 769)
Investment income		34 892 585	29 696 782
Investment management fees		(2 738 879)	(2 739 938)
Interest paid on members' savings accounts		(5 544 683)	(4 266 946)
Net cash flows from operations		(7 690 631)	15 564 129
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments		(17 310 723)	(226 391 788)
Proceeds on disposal of investments		1 881 959	241 443 740
Purchase of furniture and equipment		(59 651)	-
Cash flows from investment activities		(15 488 415)	15 051 952
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS		(23 179 046)	30 616 081
Cash and cash equivalents at beginning of the year		165 620 862	135 004 781
CASH AND CASH EQUIVALENTS AT END OF THE YEAR		142 441 816	165 620 862

NOTES TO THE SUMMARISED ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2016

1 PRINCIPAL ACCOUNTING POLICIES

These summarised financial statements set out on pages 15 to 27 have been prepared in conformity with IAS 34: Interim financial reporting. 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 summarised financial statements are prepared on the same accounting policies and methods of computation as the audited financial statements. This is based on the historical cost convention, except for investments held at fair value through surplus/deficit, which are carried at fair value. The summarised 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 1	The amendments to IAS 1 are part of the disclosure initiative which aims to improve the presentation and disclosure requirements. The amendments to IAS 1 include improvements in the following areas: - Materiality requirements in IAS 1. - Disaggregation of specific line items in profit and loss, Other Comprehensive Income and the Statement of Financial Position. - Structure of notes to the financial statements. - Requirements when additional subtotals presented in profit and loss, Other Comprehensive Income and the Statement of Financial Position. - Presentation and classification of items of Other Comprehensive Income arising from equity accounted investments.
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 34	The amendment to IAS 34 clarifies that the required interim disclosures must be either in the interim financial statements or incorporated by cross-reference between the interim financial statements and wherever they are included within the interim financial report (e.g., in the management commentary or risk report). The other information within the interim financial report must be available to users on the same terms and at the same time as the interim financial statements. The amendment must be applied retrospectively.

2 PERSONAL MEDICAL SAVINGS ACCOUNT TRUST MONIES

	2016 R	2015 R
The Scheme offers a savings plan on the Classic Option.		
Balance of personal medical savings account (PMSA) trust liability at beginning of the year	65 493 748	57 857 547
Less: Advances on savings plan accounts	(3 161 774)	(3 307 813)
Net balance of PMSA trust liability at the beginning of the year	62 331 974	54 549 734
Add:		
PMSA contributions received or receivable (refer note 4)	109 916 289	105 724 299
- for the current year	106 754 515	102 416 486
- allocated to settle prior year advances	3 161 774	3 307 813
Interest and other income earned on trust monies invested	5 544 683	4 266 946
Less:		
Transfers to other Schemes	(691 067)	(508 347)
Repayments on death or resignation	(5 343 567)	(4 610 302)
Claims paid on behalf of members	(101 013 457)	(97 090 356)
Add:		
Advances on savings plan accounts included in trade and other receivables	3 252 974	3 161 774
	73 997 829	65 493 748
Funds held in trust	74 549 865	65 898 173
	74 549 865	65 898 173

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 2016 but not recorded will amount to R2,991,809 (2015: R3,520,916) (refer note 3). 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:

	2016 R	2015 R
The investments comprises:		
- Money market trust fund	74 549 865	65 898 173
Total personal medical savings account trust monies invested	74 549 865	65 898 173

3 OUTSTANDING CLAIMS PROVISION

	2016 R	2015 R
Provision for outstanding claims	49 295 535	47 881 387
Provision arising from liability adequacy test	-	-
	49 295 535	47 881 387

The provision arising from the liability adequancy test has been considered and no additional provision was required to be raised.

Analysis of movements in outstanding claims

Balance at beginning of year	47 881 387	48 868 628
Payments in respect of prior year	(46 830 647)	(49 254 482)
Over/(under) provision in prior year	1 050 740	(385 854)
Increase in provision for the current year	48 244 795	48 267 241
Balance at end of year	49 295 535	47 881 387

Analysed as follows

Estimated gross claims	52 287 344	51 402 303
Less: Estimated recoveries from savings plan accounts	(2 991 809)	(3 520 916)
Balance at end of year	49 295 535	47 881 387

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.

3 OUTSTANDING CLAIMS PROVISION (continued)

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 2015 and 2016 benefit year.

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 2016 R	Change in liability 2015 R
3% Change in estimates	1 478 866	1 436 442
4% Change in estimates	1 971 821	1 915 255
5% Change in estimates	2 464 777	2 394 069

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 17 March 2017 are detailed below:

	2016 R	2015 R
Outstanding claims provision	49 295 535	47 881 387
Portion of outstanding claims provision paid	(44 441 561)	(43 953 488)
Residual estimate of claims incurred but not paid	4 853 974	3 927 899

4 RISK CONTRIBUTION INCOME

Gross contributions	843 398 662	820 613 145
Less: Savings contributions (refer note 2)	(109 916 289)	(105 724 299)
Risk contribution income	733 482 373	714 888 846

		2016 R	2015 R
5	**NET INCOME ON RISK TRANSFER ARRANGEMENT**		
	Carecross Pty Ltd		
	Recoveries under risk transfer arrangement	75 969 992	76 421 358
	Premiums paid in respect of risk transfer arrangement	(61 564 069)	(60 685 405)
	Net income on risk transfer arrangement	14 405 923	15 735 953

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

6	**FAIR VALUE ADJUSTMENT**		
	Realised (losses)/gains	223 872	17 114 803
	Unrealised loss on remeasurement	(2 474 948)	(15 342 063)
	Net fair value adjustment for the year	(2 251 076)	1 772 740

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

		2016 R	2015 R
7	**RELATED PARTY TRANSACTIONS**		

MMI Health Pty Ltd, 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:

Administration fees	47 673 048	47 388 074
Managed care fees	14 534 402	14 426 092
	62 207 450	61 814 166
Amount owing to MMI at year end	(4 908 493)	(1 096 191)

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 5)

Premiums paid in respect of risk transfer arrangement	61 564 069	60 685 405
Chronic claims for Essential option only	21 921	-

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 R458,139 (2015: R513,751). Net claims paid were R136,964 (2015: R540,389). The Principal officer's salary expense was R2,104,048 (2015: R1,983,555). For a breakdown of the Board of Trustees' fees and expenses, please refer Note 8.

8 TRUSTEE EXPENSES

2016

	Travel and training	Fees for meetings attendance	Total
	R	R	R
B Canning	69 031	55 524	124 555
D Simpson	2 074	55 100	57 174
H Lombard	26 568	38 748	65 316
R Strydom	2 074	50 520	52 594
E Phillips	37 966	38 748	76 714
J Mthimunye	-	4 524	4 524
J Schoeman	-	2 262	2 262
W Schroeder	2 074	41 010	43 084
	139 787	286 436	426 223

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

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.

9 EVENTS AFTER REPORTING DATE

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

NOTES TO THE SUMMARISED ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2016

10 FINANCIAL RISK MANAGEMENT

Fair value estimation

At year-end the carrying amounts approximate their fair values due to the short-term maturities of these assets and liabilities, except for investments held at fair value through surplus and deficit.

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.

	2016 R'000	2015 R'000
Financial Assets		
Level 1		
Investments held at fair value through surplus or deficit		
Cash and Deposits	100 541	125 423
Bills, Bonds and Securities	93 063	63 809
Shares	119 744	111 162
	313 348	300 394

11 SURPLUS/(DEFICIT) PER BENEFIT OPTION 2016

2016	ESSENTIAL OPTION R	CUSTOM OPTION R	HOSPICARE OPTION R	CLASSIC OPTION R	OPTIMUM OPTION R	TOTAL SCHEME R
Risk contributions	26 718 662	161 634 326	21 995 852	396 469 073	126 664 460	733 482 373
Relevant healthcare expenditure	(17 590 587)	(143 825 426)	(26 948 351)	(393 439 433)	(119 897 935)	(701 701 732)
Net claims incurred	(17 888 530)	(151 784 290)	(26 470 457)	(383 948 134)	(118 105 652)	(698 197 063)
Managed care: management services	(1 334 870)	(4 814 246)	(477 894)	(9 491 299)	(1 792 283)	(17 910 592)
Net income on risk transfer arrangements	1 632 813	12 773 110	-	-	-	14 405 923
Risk transfer arrangement expenses	(15 073 360)	(46 490 709)	-	-	-	(61 564 069)
Recoveries from risk transfer arrangements	16 706 173	59 263 819	-	-	-	75 969 992
Gross healthcare result	9 128 075	17 808 900	(4 952 499)	3 029 640	6 766 525	31 780 641
Administration expenses	(3 393 534)	(15 471 438)	(2 082 018)	(33 620 074)	(7 251 375)	(61 818 439)
Broker service fees	(477 511)	(1 540 435)	(75 552)	(1 707 156)	(166 366)	(3 967 020)
Net impairment losses on healthcare receivables	(139 608)	(1 139 180)	(59 199)	(892 458)	(208 115)	(2 438 560)
Net healthcare result	5 117 422	(342 153)	(7 169 268)	(33 190 048)	(859 331)	(36 443 378)
Other income	1 013 733	6 043 243	834 474	20 616 552	4 875 333	33 383 335
Other expenditure	(98 718)	(595 471)	(82 264)	(7 028 730)	(478 379)	(8 283 562)
Net surplus/deficit for the year	6 032 437	5 105 619	(6 417 058)	(19 602 226)	3 537 623	(11 343 605)
Number of members	3 968	8 406	826	9 256	1 352	23 808

12 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