Optima Health Plan

Medallion 4.0

Medicaid Managed Care Program

Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations

With Independent Accountant's Report Thereon

For the period of July 1, 2020 through June 30, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

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CERTIFIED PUBLIC ACCOUNTANTS

Independent Accountant's Report

Virginia Department of Medical Assistance Services
Richmond, Virginia

We have examined the accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations of Optima Health Plan (Optima) related to the Medallion 4.0 Program for the period of July 1, 2020 through June 30, 2021. Optima's management is responsible for presenting the Medical Loss Ratio and Underwriting Gain Rebate Calculations in accordance with the criteria set forth in the Medallion 4.0 contract and Centers for Medicare & Medicaid Services (CMS) federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations are in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations were prepared for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the above referenced accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations are presented in accordance with the above referenced criteria, in all material respects, for the period of July 1, 2020 through June 30, 2021. Related to non-expansion, the Adjusted Medical Loss Ratio (MLR) Percentage Achieved does not exceed the minimum requirement of eighty-five percent (85%) and the Adjusted Underwriting Gain Percentage Achieved exceeds the maximum requirement of three percent (3%). In accordance with contractual obligations, MLR and Underwriting Gain remittance amounts are due to the Department of Medical Assistance Services. Related to expansion, the Adjusted MLR Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Underwriting Gain is not applicable per contractual requirements.

This report is intended solely for the information and use of the Virginia Department of Medical Assistance Services and Optima and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC
Glen Allen, Virginia
June 14, 2023

Adjusted Medical Loss Ratio for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$638,521,541	($5,126,868)	$633,394,673
1.2	Improving health care quality expenses	$9,165,793	($2,209,320)	$6,956,473
1.3	**Total Adjusted MLR Numerator**	**$647,687,334**	**($7,336,188)**	**$640,351,146**
Medical Loss Ratio Denominator				
2.1	Revenue	$764,452,340	($3,606,947)	$760,845,393
2.2	Federal and State taxes and licensing or regulatory fees	$2,644,563	$1,566,298	$4,210,861
2.3	**Total Adjusted MLR Denominator**	**$761,807,777**	**($5,173,245)**	**$756,634,532**
Credibility Adjustment				
3.1	Member Months to determine credibility	2,195,568	0	2,195,568
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	85.0%		84.6%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**85.0%**		**84.6%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	Y		Y
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	85.0%		84.6%
5.4	MLR denominator	$761,807,777		$756,634,532
5.5	**Remittance amount due to State for Coverage Year**	**$0**		**$3,026,538**

Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$537,437,795	$9,167,510	$546,605,305
1.2	Improving health care quality expenses	$6,912,618	$0	$6,912,618
1.3	**Total Adjusted MLR Numerator**	**$544,350,413**	**$9,167,510**	**$553,517,923**
Medical Loss Ratio Denominator				
2.1	Revenue	$577,077,898	$2,944,562	$580,022,460
2.2	Federal and State taxes and licensing or regulatory fees	$1,964,268	($62,458)	$1,901,810
2.3	**Total Adjusted MLR Denominator**	**$575,113,630**	**$3,007,020**	**$578,120,650**
Credibility Adjustment				
3.1	Member Months to determine credibility	929,021	0	929,021
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	94.7%		95.7%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**94.7%**		**95.7%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	Y		Y
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	94.7%		95.7%
5.4	MLR denominator	$575,113,630		$578,120,650
5.5	**Remittance amount due to State for Coverage Year**	**N/A**		**N/A**

Adjusted Underwriting Gain for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Denominator				
1.1	Revenue	$764,452,340	($7,582,586)	$756,869,754
1.2	Federal and State taxes and licensing or regulatory fees	$2,644,563	($2,409,341)	$235,222
1.3	**Total Adjusted Underwriting Gain Denominator**	**$761,807,777**	**($5,173,245)**	**$756,634,532**
Medical Expenses				
2.1	Claims	$638,521,541	($5,126,868)	$633,394,673
2.2	Improving health care quality expenses	$9,165,793	($2,209,320)	$6,956,473
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$647,687,334**	**($7,336,188)**	**$640,351,146**
Non-Claims Costs				
3.1	Administrative Expenses	$35,873,224	$7,947,882	$43,821,106
3.2	Less: Unallowable Expenses	($1,300,573)	($393,121)	($1,693,694)
3.3	**Allowable Administrative Expenses**	**$34,572,651**	**$7,554,761**	**$42,127,412**
Underwriting Gain				
4.1	Underwriting Gain $	$79,547,792		$74,155,974
4.1	Less: Remittance Amount Due to State for Coverage Year	$0		($3,026,538)
4.2	Adjusted Underwriting Gain $	$79,547,792		$71,129,436
4.3	**Underwriting Gain %**	**10.4%**		**9.4%**
Underwriting Gain Remittance Calculation				
5.1	Member Month Requirement Met?	Y		Y
5.2	At least 12 months contract experience at the beginning of the Contract Year?	Y		Y
5.3	Percent to Remit	3.9%		3.2%
5.4	**Amount to Remit**	**$30,030,286**		**$24,215,200**

Schedule of Adjustments and Comments for the Period Ending June 30, 2021

During our examination we noted certain matters involving costs, that in our determination did not meet the definitions of allowable medical expenses and other operational matters that are presented for your consideration.

Non-Expansion Adjustment #1 – To adjust directed payments included in revenues and claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($371,612)
2.1	Revenue	($371,612)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($371,612)
2.1	Claims	($371,612)

Non-Expansion Adjustment #2 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, Health Insurer Fee (HIF) payments, Rx reinsurance payments, maternity kick payments, clinical efficacy, and performance withhold program payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	($3,235,335)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($3,235,335)

Non-Expansion Adjustment #3 – To adjust Health Insurer Fee (HIF) expense to agree with state data.

The health plan reported HIF expense utilizing trial balance information. An adjustment was proposed to report the appropriate amount of the HIF related to the period utilizing the state revenue data, as the health plan is a tax exempt 501(c)(3) organization. The Federal and State licensing and regulatory fee reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and 45 CFR § 158.161.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	$1,566,298

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.2	Federal and State taxes and licensing or regulatory fees	$1,566,298

Non-Expansion Adjustment #4 – To adjust to remove HIF expense and revenue included in the Underwriting Gain calculation.

The health plan has included HIF expense in taxes and licensing or regulatory fees and HIF revenue in revenues. HIF expense and revenue has been removed from the Underwriting Gain Calculation per the Medallion 4.0 Managed Care Services Agreement, Section 15.11.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($3,975,639)
1.2	Federal and State taxes and licensing or regulatory fees	($3,975,639)

Non-Expansion Adjustment #5 – To adjust administrative expense to apply adjustments identified during the 2020 and 2021 administrative cost procedures.

Procedures are applied to administrative costs through a separate engagement. The health plan included contributions/donations, lobbying expenses, late fees and penalties, interest on paid claims,

and bad debt, which are not considered allowable administrative expenses. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.475.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expenses	($393,121)

Non-Expansion Adjustment #6 – To adjust to reclassify non-allowable Healthcare Quality Improvement (HCQI) expenses.

The health plan reported HCQI expenses based on an analysis of cost centers determined to relate in whole or in part to HCQI. These costs centers were allocated to HCQI based on employee full time equivalent reports and job duties. The total cost allocated for HCQI included two types of costs, direct costs and indirect costs. Additionally, several of the job titles and duties included in HCQI allocation of costs did not meet the definitions of HCQI for MLR reporting purposes. These expenses have been reclassified from HCQI to administrative expenses through this adjustment. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	($2,209,320)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	($2,209,320)
3.1	Administrative Expenses	$2,209,320

Non-Expansion Adjustment #7 – To adjust to reclassify capitated payments made to Southeastrans, the transportation vendor, in excess of claims expense to administrative expense.

The health plan reported a per-member-per-month (PMPM) capitation expense for transportation services arranged by Southeastrans. During the examination, it was determined that this capitation expense was greater than the actual claims incurred and paid by Southeastrans. Since these claims were incurred for members of the Virginia Medicaid program, expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that “an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays

the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($1,511,494)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($1,511,494)
3.1	Administrative Expenses	$1,511,494

Non-Expansion Adjustment #8 – To adjust to reclassify capitated payments made to EyeMed, the vision vendor, in excess of claims expense to administrative expense.

The health plan reported a per-member-per-month (PMPM) capitation expense for vision services arranged by EyeMed. During the examination, it was determined that this capitation expense was greater than the actual claims incurred and paid by EyeMed. Since these claims were incurred for members of the Virginia Medicaid program, expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($589,714)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($589,714)
3.1	Administrative Expenses	$589,714

Non-Expansion Adjustment #9 – To adjust to reclassify claims repricing and provider network access services provided by MultiPlan from claims expense to administrative.

The health plan reported expenses related to claims repricing and provider network access services provided by MultiPlan in claims expense. During the examination, it was determined that these expenses are administrative in nature. This expense has been reclassified from claims to administrative expenses. Incurred claims are defined in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($581,906)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($581,906)
3.1	Administrative Expenses	$581,906

Non-Expansion Adjustment #10 – To adjust to reclassify capitated payments made to DentaQuest, the dental vendor, in excess of claims expense to administrative expense.

The health plan reported a per-member-per-month (PMPM) capitation expense for dental services arranged by DentaQuest. During the examination, it was determined that this capitation expense was greater than the actual claims incurred and paid by DentaQuest. Since these claims were incurred for members of the Virginia Medicaid program, expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that “an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees”. Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ –

Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($312,141)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($312,141)
3.1	Administrative Expenses	$312,141

Non-Expansion Adjustment #11 – To adjust to include fraud reduction expense, up to the amount of recoveries.

The health plan reported fraud recoveries on the as-filed template, however, did not report fraud reduction expense. Due to the fraud reduction expense not being reported, the fraud recoveries were not included in the as-filed numerator. An adjustment was proposed to include the amount of fraud reduction expenses, limited by their fraud recoveries amounts, in claims expense to offset the amounts previously reported in their claims totals in the MLR calculation. The fraud reduction expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(iii)(B).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$260,784

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$260,784

Non-Expansion Adjustment #12 – To adjust pharmacy expenses related to OptumRx to actual costs incurred.

The health plan reported claims expenses net of rebates for pharmacy services arranged by OptumRx. During the examination, it was determined that claims and rebates were understated in comparison to the amount reported by OptumRx. OptumRx also reported offsetting revenue received from pharmacies related to pricing and discount guarantees. Expense was adjusted to agree to claims, rebates, and pricing and discount guarantees reported by OptumRx.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19),

5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($143,395)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($143,395)
3.1	Administrative Expenses	$143,395

Non-Expansion Adjustment #13 – To adjust Incurred but Not Reported (IBNR) at the time of the MLR filing to IBNR as of March 2023.

The reported IBNR of $1,585,523 was adjusted to agree to the March 2023 lag table. We have made an adjustment for the difference of $443,127 to Medical Loss Ratio line 1.1 and Underwriting Gain line 2.1. The IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$443,127

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$443,127

Non-Expansion Adjustment #14 – To adjust to reclassify capitated payments made to Optima Behavioral Health, the related party behavioral health vendor, in excess of claims expense to administrative expense.

The health plan reported a per-member-per-month (PMPM) capitation expense for behavioral health services arranged by Optima Behavioral Health, which is a related party. During the examination, it was

determined that this capitation expense was greater than the actual claims incurred and paid by Optima Behavioral Health. Since these claims were incurred for members of the Virginia Medicaid program, expense was adjusted to actual claims cost utilizing supporting lag table documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($2,320,518)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($2,320,518)
3.1	Administrative Expense	$2,320,518

Non-Expansion Adjustment #15 – To adjust administrative expense to agree to supporting documentation.

The health plan reported administrative expenses at $35,873,224. Based on supporting documentation received, administrative expenses were determined to be $36,152,618. The expenses were adjusted to agree to the provided supporting documentation. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.475.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.1	Administrative Expenses	$279,394

Expansion Adjustment #1 – To adjust directed payments included in revenues and claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$9,167,510
2.1	Revenue	$9,167,510

Expansion Adjustment #2 – To adjust Revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, Health Insurer Fee (HIF) payments, Rx reinsurance payments, maternity kick payments, clinical efficacy, and performance withhold program payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	($6,222,947)

Expansion Adjustment #3 – To adjust HIF expense to agree with state data.

The health plan reported HIF expense utilizing trial balance information. An adjustment was proposed to report the appropriate amount of the HIF related to the period utilizing the state revenue data, as the health plan is a tax exempt 501(c)(3) organization. The Federal and State licensing and regulatory fee reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and 45 CFR § 158.161.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	($62,458)