SIERRA HEALTH SERVICES INC
Form 10-K
March 29, 2002

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

X ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2001

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to_____

Commission file number: 1-8865

SIERRA HEALTH SERVICES, INC.
(Exact name of Registrant as specified in its charter)

NEVADA	**88-0200415**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

2724 NORTH TENAYA WAY
LAS VEGAS, NEVADA 89128
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (702) 242-7000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common Stock, par value $.005	**New York Stock Exchange**

Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. **YES X** NO

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [ ]

The aggregate market value of the voting stock held by non-affiliates of the registrant on March 18, 2002 was $291,259,000.

The number of shares of the registrant's common stock outstanding on March 18, 2002 was 28,111,000.

DOCUMENTS INCORPORATED BY REFERENCE

DOCUMENT	WHERE INCORPORATED
Portions of the registrant's definitive proxy statement for Part III its 2001 annual meeting to be filed with the SEC not later than 120 days after the end of the fiscal year.	Part III

SIERRA HEALTH SERVICES, INC.

2001 Form 10-K

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PART I

ITEM 1. DESCRIPTION OF BUSINESS

GENERAL

Unless otherwise indicated, "Sierra," "we," "us," and "our" refer to Sierra Health Services, Inc. and its subsidiaries.

We are a managed health care organization that provides and administers the delivery of comprehensive health care and workers' compensation programs with an emphasis on quality care and cost management. Our strategy has been to develop and offer a portfolio of managed health care and workers' compensation products to employer groups and individuals. Our broad range of managed health care services is provided through the following:

- federally qualified health maintenance organizations or HMOs
- managed indemnity plans
- a third-party administrative services program for employer-funded health benefit plans
- workers' compensation medical management and fully insured program
- ancillary products and services that complement our managed health care and workers' compensation product lines
- a subsidiary that administers a managed care federal contract for the Department of Defense's TRICARE program in Region 1

Operating results and cash flows from continuing operations for fiscal year 2001 reflected significant improvement over the prior year. Fiscal year 2000 was a difficult year for us. In the first and second quarters of 2000, we evaluated and then announced and adopted restructuring plans related primarily to our Texas HMO health care operations. This restructuring involved a reduction in staff and the closing of some of our Texas clinic facilities, which resulted in our recording the write off of a significant portion of our goodwill and fixed asset impairment and other charges totaling approximately $220 million.

Throughout 2001, we continued to focus on making the Texas HMO health care operations profitable. Significant premium rate increases were made on renewing membership and during the third quarter we embarked on a recontracting effort to reduce medical costs. It was during this recontracting effort that unsustainable cost increases were identified, including the fact that the operations' primary hospital contract if renewed, would be at a substantially higher rate than was previously indicated by the hospital.

Although considerable efforts had been made to achieve profitability in our Texas HMO health care operations, it was determined that under the current operating environment, we would not be able to turn around the operating results and the best course of action was to exit the market as soon as possible to limit future losses and exposure. As part of our plan to exit Texas, in the third quarter of 2001, we recorded a charge of $17.1 million for premium deficiency costs, the write down of certain assets, legal and restitution costs, and various other exit related costs. We will cease providing HMO health care coverage in Texas on April 17, 2002.

We have elected to early adopt Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" or SFAS No. 144, effective January 1, 2001. In accordance with SFAS No. 144 our Texas HMO health care operations have been reclassified and presented as discontinued operations. Unless otherwise indicated, information presented in this 2001 Form 10-K is for continuing operations and excludes the discontinued Texas HMO health care operations.

Revolving Credit Facility. As a result of the asset impairment and other changes in estimate charges, we were not in compliance with the revolving credit facility financial covenants at June 30, 2000. On December 15, 2000, we entered into an amended and restated credit agreement, which terminates on September 30, 2003, and are now in compliance with all covenants of the amended agreement. The amended agreement was further amended in April 2001 to allow for the completion of the debenture exchange offer and again in October 2001 to provide a limited waiver for covenants affected by exiting the Texas HMO health care market. The availability under the credit facility has been reduced to $117 million at December 31, 2001 from $135 million at the end of 2000 due to required reductions in the agreement. We have $28 million available under the credit facility; however, the total availability will be reduced by $6.0 million on June 30, 2002 and December 31, 2002 and finally by $10.0 million on June 30, 2003. The amount available under the credit facility can be further reduced by 80% of net proceeds from certain asset sales and annual excess cash flows, as well as 100% of the net proceeds of any new debt or equity issuance, excluding any issuance by CII, as defined in the amended and restated credit agreement. The amended and restated credit agreement restricts the amount of funds that can be transferred to the Texas and Sierra Military Health Services, Inc., or SMHS, operations. The amount outstanding under the credit facility fluctuates with our working capital needs.

Debentures. At September 30, 2000, CII Financial, our wholly-owned workers' compensation subsidiary, had outstanding approximately $47.1 million of subordinated debentures that were due on September 15, 2001. These subordinated debentures were neither assumed nor guaranteed by Sierra and were subordinated to Sierra's credit facility debt. In December 2000, CII Financial commenced an offer to exchange the subordinated debentures for cash and/or new debentures. On May 7, 2001, CII Financial closed its exchange offer on $42.1 million of its outstanding subordinated debentures. CII Financial purchased $27.1 million in principal amount of subordinated debentures for $20.0 million in cash and issued $15.0 million in new 9 1/2% senior debentures, due September 15, 2004, in exchange for $15.0 million in subordinated debentures. The transaction was accounted for as a restructuring of debt; therefore all future cash payments, including interest, related to the debentures will be reductions of the carrying amount of the debentures and no future interest expense will be recognized. Accordingly, the new 9 1/2% senior debentures have a carrying amount of $19.2 million, which consists of principal of $15.0 million and $4.2 million in future accrued interest.

In September 2001, the California Department of Insurance gave approval to California Indemnity, one of CII Financial's insurance subsidiaries, to pay a dividend of $5.0 million to CII Financial. CII Financial used these funds to pay

the remaining $5.0 million in subordinated debentures at maturity. CII Financial expects to service the new 9 1/2% senior debentures from future cash flows, primarily from dividends that will be paid by its insurance subsidiaries from their future earnings.

Other. Our principal executive offices are located at 2724 North Tenaya Way, Las Vegas, Nevada 89128, and our telephone number is (702) 242-7000.

Our fiscal year period is the same as the calendar year and unless otherwise indicated, any year designated will refer to the year ended December 31.

Managed Care Products and Services

Our primary types of health care coverage are HMO plans, HMO Point of Service, or POS plans, and managed indemnity plans, which include a preferred provider organization, or PPO option. The POS products allow members to choose one of the various coverage options when medical services are required instead of one plan for the entire year. As of December 31, 2001, we provided HMO products to approximately 247,000 members in Nevada. We also provide managed indemnity products to approximately 29,000 members, Medicare supplement products to approximately 23,000 members, and administrative services to approximately 289,000 members. Medical premiums account for approximately 56% of total revenues.

Health Maintenance Organizations. We operate a mixed model HMO in Las Vegas, Nevada, which means that we use our own specialty medical group as well as a network of independently contracted providers. We also operate a network model HMO in Reno, Nevada. Our network model HMO, in Dallas, Texas, will operate through April 17, 2002. Independently contracted primary care physicians and specialists for the HMOs are compensated on a capitation or modified fee-for-service basis. Contracts with our primary hospitals are on a discounted per diem basis. Members receive a wide range of coverage after paying a nominal co-payment and are eligible for preventive care coverage. The HMOs do not require deductibles or claim forms when the member receives HMO benefits. We have over 50% of the Las Vegas HMO market share.

Most of our managed health care services in Nevada are provided through our independently contracted network of approximately 2,000 providers and 13 hospitals. These Nevada networks include our affiliated multi-specialty medical group, which provides medical services to approximately 75% of our southern Nevada HMO members and employs over 180 primary care and other providers in various medical specialties. Through our affiliates, the following services are offered:

- three urgent care centers
- home health care
- hospice care
- behavioral health care
- home infusion, oxygen and durable medical equipment
- a free-standing, state-licensed and Medicare-approved ambulatory surgery center
- radiology
- vision
- occupational medicine

We believe that this vertical integration of our health care delivery system in southern Nevada provides a competitive advantage as it helps us to effectively manage health care costs while delivering quality care.

On October 24, 2000, Texas Health Choice, L.C., or TXHC, entered into an agreement with AmCare Health Plans of Texas, Inc., or AmCare, for the sale and transfer of TXHC's membership in Houston. Effective December 1, 2000, AmCare assumed the risk associated with the commercial HMO and Medicare+Choice, or M+C, member contracts under an assumption reinsurance agreement with TXHC. We did not receive material sales proceeds from this transaction.

On October 1, 2001 TXHC entered into another agreement with AmCare to offer replacement coverage to all small and large groups covered by TXHC. The offer applied to approximately 30,000 members and currently, we believe approximately 8,000 members have, or will, accept the AmCare replacement coverage. We do not expect to receive material sales proceeds from this transaction.

Our commercial plans offer traditional HMO benefits and POS benefits. At December 31, 2001, we had approximately 175,000 commercial members in Nevada.

We offer a Medicare risk product for Medicare-eligible beneficiaries called Senior Dimensions. Senior Dimensions is marketed directly to Medicare-eligible beneficiaries. The monthly payment received from the Centers for Medicare and Medicaid Services, or CMS, formerly known as the Health Care Financing Administration, or HCFA, for Medicare members is determined by formula established by Federal law.

As of December 31, 2001, we had approximately 45,000 Medicare members in Nevada. Approximately 39,000 of the Medicare members were enrolled in the Social HMO, which is discussed below.

In addition, as of December 31, 2001, we had approximately 27,000 members enrolled in our Nevada HMO Medicaid risk products. To enroll in these products, an individual must be eligible for Medicaid benefits in the state of Nevada. We are paid a monthly fee for each Medicaid member enrolled by the state's managed care division.

Social Health Maintenance Organization. Effective November 1, 1996, we entered into a Social HMO II contract with CMS pursuant to which a large portion of our Nevada Medicare risk enrollees will receive certain expanded benefits. We are one of six HMOs nationally to be awarded this contract and are the only company to have the program implemented as of December 31, 2001. We receive additional revenues for providing these expanded benefits. The additional revenues are determined based on health risk assessments that have been, and will continue to be, performed on our eligible Medicare risk members. The additional benefits include, among other things, assisting the eligible Medicare risk members with typical daily living functions such as bathing, dressing and walking. These members, as identified in the health risk assessments, are those who currently have difficulty performing daily living functions because of a health or physical problem. CMS may consider adjusting the reimbursement factors for the Social HMO members in the future. At this time, however, the final reimbursement per member for 2003 has not been determined and there is no guaranty that the Social HMO contract will be renewed beyond 2003. It should be noted that Congress has in the past agreed to extend the contract. If the reimbursement for these members decreases significantly and related benefit changes are not made timely, there could be a materially adverse effect on our business.

Preferred Provider Organizations. Our managed indemnity plans generally offer members a PPO option of receiving their medical care from either contracted or non-contracted providers. Members pay higher deductibles and co-insurance or co-payments when they receive care from non-contracted providers. Out-of-pocket

costs are lowered by utilizing contracted providers who are part of our PPO network. As of December 31, 2001, approximately 29,000 members were enrolled in our managed indemnity plans.

During 2001, we provided managed indemnity, accidental death and disability and Medicare supplement services to individuals in Arizona, California, Colorado, Iowa, Louisiana, Maryland, Nevada, New Mexico and Texas. As of December 31, 2001, our managed indemnity subsidiary was licensed in a total of 43 states and the District of Columbia.

Ancillary Medical Services. Among the ancillary medical services we offer in Nevada are the following:

- outpatient surgical care
- diagnostic testing
- medical and surgical procedures
- x-ray
- CAT scans
- mental health and substance abuse services
- home health care services
- hospice program
- vision services
- home infusion
- oxygen
- durable medical equipment services

These services are provided to members of our HMO, managed indemnity and administrative service plans. Mental health and substance abuse services are also provided to approximately 152,000 participants from non-affiliated employer groups and insurance companies.

Administrative Services. Our administrative services products provide, among other things, utilization review and PPO services to large employer groups that are usually self-insured. As of December 31, 2001, approximately 289,000 members were enrolled in our administrative services plans. The results of operations for these services are included in specialty product revenues and expenses in the Consolidated Statements of Operations.

Military Contract Services

Sierra Military Health Services, Inc. On September 30, 1997, the Department of Defense, or DoD, awarded us a triple-option health benefits contract, known as TRICARE, to provide managed health care coverage to eligible beneficiaries in Region 1. This region has approximately 639,000 eligible individuals in Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia and Washington, D.C. SMHS completed an eight month implementation phase in May 1998 and began providing health care benefits on June 1, 1998 under the TRICARE contract.

Under the TRICARE contract, SMHS provides health care services to dependents of

active duty military personnel and military retirees and their dependents through subcontractor partnerships and individual providers. We also perform specific administrative services, including health care appointment scheduling, enrollment, network management and health care management services. We perform these services using DoD information systems. If all five option periods are exercised by the DoD and no extensions of the performance period are made, health care delivery will end on May 31, 2003, followed by an additional eight month phase out of the Region 1 managed care support contract. The DoD has extended expiring TRICARE contracts in other regions and SMHS has recently begun negotiations with the DoD about a possible extension to the base contract.

In June 1996, the DoD awarded a TRICARE contract to TriWest Health Care Alliance, a consortium consisting of Sierra and 13 other health care companies, to provide health services to Regions 7 and 8, which include a total of 16 states. During the first quarter of 2000, we sold our interest in TriWest Health Care Alliance in exchange for a $3.7 million note, which approximated the carrying value of our investment. The note was completely paid by the first quarter of 2001.

Workers' Compensation Operations

Workers' Compensation Subsidiary. On October 31, 1995, we acquired CII Financial, Inc., or CII, for approximately $76.3 million of common stock in a transaction accounted for as a pooling of interests. Through CII's insurance subsidiaries, we write workers' compensation insurance in California, Colorado, Kansas, Missouri, Nebraska, Nevada, New Mexico, Texas and Utah. CII's insurance subsidiaries have licenses in 36 states and the District of Columbia and have applications pending for licenses in other states. California, Colorado and Nevada represent approximately 72%, 9%, and 10%, respectively, of CII's fully insured workers' compensation insurance premiums in 2001. Workers' compensation insurance premiums account for approximately 14% of our total revenue. The workers' compensation subsidiary applies the discipline of managed care concepts to its operations. These concepts include, but are not limited to, the use of specialized preferred provider networks, utilization reviews by an employed board certified occupational medicine physician as well as nurse case managers, medical bill reviewers and job developers who facilitate early return to work.

Marketing

The marketing and sales of our commercial managed care products typically involve a multi-step process involving our sales representatives, a consultant/broker appointed by the client and the client. Once a relationship with a group has been established and a group agreement is negotiated and signed, we focus our marketing efforts on individual employees. During a designated "open enrollment" period each year, usually the month preceding the annual renewal of the agreement with the group, employees choose whether to remain with, join or terminate their membership with a specific health plan offered by the employer. New employees decide whether to join one of the employers' heath insurance options at the time of their employment. Although contracts with employers are generally terminable on 60 days notice, changes in membership occur primarily during open enrollment periods.

Media communications convey our emphasis on access to our broad health care provider network and services at a reasonable price. Other communications to customers include employer and member newsletters, member education brochures, prenatal information packets, employer/broker seminars, certain Internet information and direct mail advertising to clients. Members' satisfaction with our benefits and services is monitored by customer surveys. Results from these surveys and other primary and secondary research guide the sales and advertising efforts throughout the year.

Medicare risk products are primarily marketed by the HMOs' sales employees.

Retention of employer groups and membership growth is accomplished through print advertising directed to employers and through consumer media campaigns.

Our workers' compensation insurance policies are sold through independent insurance agents and brokers, who may also represent other insurance companies. We believe that independent insurance agents and brokers choose to market our insurance policies primarily because of the price we charge, the quality of service that we provide and the commissions we pay. As of December 31, 2001, we had relationships with approximately 756 agents and paid our agents commissions based on a percentage of the gross written premium they produced. We also have various agency incentive programs that enable certain agents to earn additional compensation if certain premium production and/or agency loss ratio goals are met. We utilize a number of promotional media, including advertising in publications to support the efforts of our independent agents.

SMHS administers marketing initiatives in accordance with the TRICARE Region 1 managed care support contract. SMHS' dedicated marketing division uses a multi-faceted marketing approach to ensure that beneficiaries within Region 1 have the opportunity to learn about the health care benefits under TRICARE and have the opportunity to make health care choices that best fit their specific needs. Marketing initiatives include direct beneficiary briefings, direct mail, newspaper advertising, newsletters and Internet web page briefs.

Membership

Period End Membership:

	At December 31,			
	2001	**2000**	**1999**	**19**
Continuing Operations:				
HMO:				
Commercial	175,000	140,000	149,000	146
Medicare	45,000	42,000	42,000	37
Medicaid	27,000	15,000	11,000	5
Managed Indemnity	29,000	31,000	37,000	41
Medicare Supplement	23,000	28,000	28,000	26
Administrative Services	289,000	273,000	298,000	318
TRICARE Eligibles	639,000	621,000	610,000	606
Total Membership, Continuing Operations	1,227,000	1,150,000	1,175,000	1,179
Discontinued Operations:				
HMO:				
Commercial	43,000	73,000	114,000	126
Medicare	12,000	8,000	11,000	10
Total Membership, Discontinued Operations	55,000	81,000	125,000	136

During 2001, 2000 and 1999, we received approximately 23.6%, 23.1% and 23.4%, respectively, of our total revenues from our contract with CMS to provide health care services to Medicare enrollees. Our contract with CMS is subject to annual renewal at the election of CMS and requires us to comply with federal HMO and Medicare laws and regulations and may be terminated if we fail to comply. The termination of our contract with CMS could have a material adverse effect on our business. In addition, there have been, and we expect that there will continue to be, a number of legislative proposals to limit Medicare reimbursements and to

require additional benefits. Future levels of funding of the Medicare program by the federal government cannot be predicted with certainty. (See Government Regulation and Recent Regulation).

Our ability to obtain and maintain favorable group benefit agreements with employer groups affects our profitability. The agreements are generally renewable on an annual basis but are subject to termination on 60 days prior notice. For the fiscal year ended December 31, 2001, our ten largest HMO employer groups were, in the aggregate, responsible for less than 10% of our total revenues. Although none of our employer groups accounted for more than 2% of total revenues during that period, the loss of one or more of the larger employer groups could, if not replaced with similar membership, have a material adverse effect upon our business. We have generally been successful in retaining these employer groups in Nevada. However, there can be no assurance that we will be able to renew our agreements with our employer groups in the future or that we will not experience a decline in enrollment within our employer groups. Additionally, revenues received under certain government contracts are subject to audit and retroactive adjustment.

Provider Arrangements and Cost Management

HMO and Managed Indemnity Products. A significant distinction between our health care delivery system and that of many other managed care providers is the fact that approximately 75% of our southern Nevada HMO members receive primary health care through our own multi-specialty medical group. We make health care available through independently contracted providers employed by the multi-specialty medical group and other independently contracted networks of physicians, hospitals and other providers.

Under our HMOs, the member selects a primary care physician who provides or authorizes any non-emergency medical care given to that member. These primary care physicians and some specialists are compensated to a limited extent on the basis of how well they coordinate appropriate medical care. We have a system of limited incentive risk arrangements and utilization management with respect to our independently contracted primary care physicians. We compensate our independently contracted primary care physicians and specialists by using both capitation and modified fee-for-service payment methods. In Nevada, under the modified fee-for-service method, a limited incentive risk arrangement is established for institutional services. Additional amounts may be made available to certain capitated physicians if hospital costs are less than anticipated for our HMO members. For those primary care physicians receiving payments on a modified fee-for-service basis, portions of the payments otherwise due the physicians are withheld. The amounts withheld are available for payment to the physicians if, at year-end, the expenditures for both institutional and non-institutional medical services are within established ranges. It is believed that this method of limited incentive risk payment is advantageous to the physician, our company and the members because all share in the benefits of managing health care costs. We have, however, negotiated capitation and reduced fee-for-service agreements with certain specialists and primary care providers who do not participate in the incentive risk arrangements. We monitor certain health care utilization, including evaluation of elective surgical procedures, quality of care and financial stability of our capitated providers, to facilitate access to service and to ensure member satisfaction.

We provide or negotiate discounted contracts with hospitals for inpatient and outpatient hospital care, including room and board, diagnostic tests and medical and surgical procedures. We believe that we currently have a favorable contract with our primary southern Nevada contracted hospitals, Sunrise Hospital and Medical Center and Mountain View Hospital. Subject to certain limitations, the contract provides, among other things, guaranteed contracted per diem rate increases on an annual basis. The per diem rate increased 4% in 2001 and is scheduled to increase approximately 8% for commercial members in 2002. The

scheduled rate increase for 2002 has been factored into our 2002 premium rate increases. Our contract with Sunrise Hospital and Medical Center and Mountain View Hospital contains a clause which requires them to provide us with their best rates in the market place. Since a majority of our southern Nevada hospital days are at these facilities, this contract assists us in managing a significant portion of our medical costs. We can be and have been affected by these hospital's limited capacity and have had to place our members in other facilities, some with a higher cost to us, due to a shortage of beds at these hospitals. In general, our other hospital contracts in Las Vegas are based on a fixed per diem rate structure.

We believe that we have negotiated favorable rates with our contracted hospitals. For hospitals other than Sunrise and Mountain View Hospitals, our contracts with our hospital providers typically renew automatically with both parties granted the right to terminate after a notice period ranging from three to twelve months. We are currently in negotiations with one Las Vegas hospital that has given us notice of their intent to terminate the contract effective October 23, 2002. Reimbursement arrangements with other health care providers, including pharmacies, generally renew automatically or are negotiated annually and are based on several different payment methods, including per diems (where the reimbursement rate is based on a per day of service charge for specified types of care), capitation or modified fee-for-service arrangements. To the extent possible, when negotiating non-physician provider arrangements, we solicit competitive bids.

We utilize two reimbursement methods for health care providers rendering services under our indemnity plans. For services to members utilizing a PPO plan, we reimburse participating physicians on a modified fee-for-service basis, which incorporates a limited fee schedule and reimburses hospitals on a per diem or discounted fee-for-service basis. For services rendered under a standard indemnity plan, pursuant to which a member may select a non-plan provider, we reimburse non-contracted physicians and hospitals at pre-established rates, less deductibles and co-insurance amounts.

We manage health care costs through our large case management program, utilization review, monitoring care in the appropriate setting and by educating our members on how and when to use the services of our plans and how to manage chronic disease conditions. We audit hospital bills and review hospital and high volume providers' claims to ensure appropriate billing and utilization patterns. We also monitor the referral process from the primary care physician to the specialty network for appropriateness. Further, in Nevada, we utilize our home health care agency and our hospice, which help to minimize hospital admissions and the length of stay.

Military Contract Services. Under the TRICARE contract, dependents of active duty military personnel and military retirees and their dependents choose one of three option plans available to them for health care services: (i) TRICARE Prime (an HMO style option with a self-selected primary care manager and no deductibles), (ii) TRICARE Extra (a PPO style option with deductibles and cost shares) or (iii) TRICARE Standard (an indemnity style option with deductibles and cost shares). Approximately 36% of eligible beneficiaries receive their primary care through existing military treatment facilities. SMHS negotiated discounted contracts with approximately 32,000 individual providers, 2,000 institutions and 8,000 pharmacies to provide supplemental network access for TRICARE Prime and Extra beneficiaries. SMHS' contracts with providers are primarily on a discounted fee-for-service basis with renewal and termination terms similar to our commercial practice. SMHS is at-risk for and manages the health care service cost of all TRICARE Extra and Standard beneficiaries as well as a small percentage of TRICARE Prime beneficiaries.

SMHS implemented the TRICARE Senior Pharmacy Program, or Senior RX, on April 1, 2001. The Senior RX program enables Military Health Services Medicare eligible

beneficiaries, age 65 and over, to obtain prescription drugs, and the supplies necessary for the administration of pharmaceuticals, from a network retail pharmacy, non-network retail pharmacy or through the National Mail Order Pharmacy. SMHS does not assume any risk under this new program.

On October 1, 2001, SMHS implemented the TRICARE for Life program. This new DoD program provides continued TRICARE coverage to military family retirees over the age of 65 as a supplement to Medicare. SMHS does not assume any risk under this new program.

Risk Management

We maintain general and professional liability and property and fidelity insurance coverage in amounts that we believe are adequate for our operations. Effective June 15, 2001 our health care organization and provider liability policy, combined with our managed care organization errors and omissions liability policy, provides insurance for professional, managed care, general and employee benefit exposures with a self insured retention of $500,000 per claim and a liability limit of $10 million per claim. Our combined self insured retention aggregate limit on this policy is $15 million. We also have an excess professional liability policy which insures these risks for an additional $15 million per claim and in the aggregate. Acts of liability prior to June 15, 2001 were insured as follows: Nevada and Arizona liabilities for medical malpractice were insured per claim and in the aggregate with a total limit of $20 million (less any previous claims against the aggregate) with a self insured retention of $250,000 per claim with an aggregate retention of $1.5 million. Prior to June 15, 2001, medical malpractice liability in Texas had a total limit of $30 million (less any previous claims against the aggregate) with first dollar coverage. All managed care risks prior to June 15, 2001 was insured to a $25 million liability limit (less any previous claims against the aggregate) with a $15,000 deductible per claim. In addition, we require all of our independently contracted provider physician groups, individual practice physicians, specialists, dentists, podiatrists and other health care providers (with the exception of certain hospitals) to maintain professional liability coverage. Certain of the hospitals with which we contract are self-insured. We also maintain stop-loss insurance that reimburses us between 50% and 90% of hospital charges for each individual member of our HMO or managed indemnity plans whose hospital expenses exceed, depending on the contract, $75,000 to $200,000, during the contract year and up to $2.0 million per member per lifetime.

We also maintain excess catastrophic coverage for one of our wholly-owned HMOs, Health Plan of Nevada, Inc., or HPN, that reimburses us for amounts by which the ultimate net loss exceeds $400,000, but does not exceed the annual maximum of $19.6 million per occurrence and $39.2 million per contract. In the ordinary course of business, we are subject to claims that are not insured, principally claims for punitive damages.

Effective July 1, 1998, all workers' compensation claims with dates of injury occurring on or after that date were reinsured under a quota share and excess of loss agreement, which we refer to as "low level" reinsurance, with Travelers Indemnity Company of Illinois, or Travelers. Travelers is rated AA and A++ by Fitch Ratings and the A.M. Best Company, respectively. The low level reinsurance provided quota share protection for 30% of the first $10,000 of each loss, and excess of loss protection of 75% of the next $40,000 of each loss, and 100% of the next $450,000 on a per occurrence basis. The maximum net loss retained on any one claim ceded under this treaty was $17,000. This agreement continued until June 30, 2000, when we exercised an option for a twelve month extension relating to the run-off of policies in force as of June 30, 2000, which covered claims arising under such policies during the term of the extension.

In addition to the low level reinsurance, effective January 1, 2000 we entered into a reinsurance contract that provides statutory (unlimited) coverage for

workers' compensation claims in excess of $500,000 per occurrence. The contract is in effect for claims occurring on or after January 1, 2000 through December 31, 2002. There is a twelve month run out provision in the contract which we intend to execute. The reinsurer, National Union Fire Insurance Company, is rated AAA and A++ by Fitch Ratings and the A.M. Best Company, respectively.

When the low level reinsurance agreement expired on June 30, 2000, as a result of a general tightening of the reinsurance market as well as the impact of the increased loss experience in California, a comparable type of reinsurance program was unavailable in the market and those reinsurers which were offering other forms of lower retention programs were charging premiums that we believed were not cost justified. Therefore, effective July 1, 2000, we entered into a reinsurance contract with National Union Fire Insurance Company that provided $250,000 of coverage for workers' compensation claims in excess of $250,000 per occurrence. The contract was in effect for claims occurring on policies with effective dates beginning July 1, 2000 and thereafter and for claims incurred prior to July 1, 2001. As a result of the general tightening of the reinsurance market, we expect all of our insurance costs to increase significantly upon renewal.

Information Systems

We use information systems to support, among other things, pricing our services, monitoring utilization and other cost factors, providing bills on a timely basis, identifying accounts for collection, processing claims for reimbursement, delivering customer service and handling various accounting and reporting functions. In 2001, we upgraded some of our core application systems to more current releases to ensure that we maintain the vendors' support for ongoing maintenance and enhancements. We also expanded our secure Internet-based access to basic eligibility, benefits and claims information to health care providers, covered members, group customers and brokers. We view our information systems capability as critical to the performance of ongoing administrative functions and integral to quality assurance and the coordination of patient care. We are continually modifying or improving our information systems capabilities in an effort to improve operating efficiencies and service levels.

Quality Assurance and Improvement

We promote continuous improvement in the quality of member care and service through our quality programs. Our quality programs are a combination of quality assurance activities, including the retrospective monitoring and problem solving associated with the quality of care delivered and continuous quality improvement activities including the trending and analysis of ongoing aggregate data for purposes of prospective planning.

Our quality assurance methodology is based on (i) reviews of adverse health outcomes as well as appropriateness and quality of care; (ii) focused reviews of high volume/high risk diagnoses or procedures; (iii) monitoring for trends; (iv) peer review of the clinical process of care; (v) development and implementation of corrective action plans, as appropriate; (vi) monitoring compliance/adherence to corrective action plans; and (vii) assessment of the effectiveness of the corrective action plans.

Our quality improvement methodology is based on (i) collection and analysis of data; (ii) analysis of barriers to achieving goals and/or benchmarks; (iii) development and implementation of interventions to address barriers; (iv) remeasurement of data to assess effectiveness of interventions; (v) development and implementation of new or additional interventions, as appropriate; and (vi) follow-up remeasurement of data to assess effectiveness or sustained impact.

Several independent organizations have been formed for the purpose of responding to external demands for accountability in the health care industry. We have

voluntarily elected to be evaluated by two of these external organizations, the National Committee for Quality Assurance, or NCQA, and the American Accreditation Healthcare Commission, or URAC. NCQA is an independent, not-for-profit organization that evaluates managed care organizations. URAC is a non-profit charitable organization founded in 1990 to establish standards for the managed care industry.

The NCQA accreditation process includes rigorous evaluations conducted by a team of physicians and managed care experts. According to NCQA officials, the standards are purposely set high to encourage health plans to continuously enhance their quality. No comparable evaluation exists for fee-for-service health care. NCQA evaluates plans on approximately 50 quality standards that fall into six categories: quality management and improvement; physician credentials; members' rights and responsibilities; preventive health services; utilization management; and medical records. In 2000, HPN earned an "Accredited" status from the NCQA for its HMO and Medicare products.

HPN, Sierra Health and Life Insurance Co. Inc., or SHL, Sierra Healthcare Options, Inc. and Behavioral Healthcare Options, Inc. utilization management operations were "Fully Accredited" by URAC, under URAC's "Health Utilization Management, or UM, Standards" program. URAC's health UM accreditation program is the largest and most recognized program of its type in the United States. The health UM standards are meant to ensure organizations follow a process that is clinically sound, promotes quality care and respects members' rights. The health UM standards address eight categories including the following: confidentiality, staff qualifications, program qualifications, information upon which organizations conduct UM, procedures for review determination and procedures for appeals of determinations not to certify (expedited and standard appeals). Once the review team is satisfied that the organization is in compliance with the Standards, the accreditation application is forwarded to the URAC Accreditation committee. This Committee consists of representatives from the URAC member organizations and industry experts. Final approval for accreditation is made by URAC's executive committee. URAC accreditation is awarded for two years, we received our latest accreditation in 2001.

There can be no assurance, however, that we will maintain NCQA or other accreditations in the future and there is no basis to predict what effect, if any, the lack of NCQA or other accreditations could have on HPN's competitive position in Nevada.

Underwriting

HMO. We structure premium rates for our various health plans primarily through a community rating by class method. Under the community rating by class method, all costs of basic benefit plans for our entire membership population are aggregated. These aggregated costs are calculated on a "per member per month" basis and converted to premium rates for various coverage types, such as single or family coverage. Actuarial adjustments to premium rates are made for demographic variations specific to each employer group including the average age and sex of their employees, group size and industry. All employees of an employer group are charged the same premium rate if the same coverage is selected.

In addition to premiums paid by employers, members also pay co-payments at the time certain services are provided. We believe that co-payments encourage appropriate utilization of health care services while allowing us to offer competitive premium rates. We also believe that the capitation method of provider compensation encourages physicians to provide only medically necessary and appropriate care.

Managed Indemnity. Premium charges for our managed indemnity products are set in a manner similar to the community rating by class method described above. This

rate calculation utilizes similar demographic adjustment factors including age, sex and industry factors to develop group-specific adjustments from a given per member per month base rate by plan. Actual health claim experience is used in whole or in part to develop premium rates for larger insurance member groups. This process includes the use of utilization experience, adjustments for incurred but not reported claims, inflationary factors, credibility and specific reinsurance pooling levels for large claims.

Workers' Compensation. Prior to insuring a particular risk, we review, among other factors, the employer's prior loss experience and other pertinent underwriting information. Additionally, we determine whether the employer's employment classifications are among the classifications that we have elected to insure and if the amounts of the premiums for the classifications are within our guidelines. We review these classifications periodically to evaluate whether they are profitable. Of the approximately 500 employment classifications in California, we are willing to insure approximately one-half. The remaining classifications are either excluded by our reinsurance treaty or are believed by us to be too hazardous or not profitable. In addition, we increase our requirements for certain classifications to increase the likelihood of profitability.

Once an employer has been insured by us, our loss control department may assist the insured in developing and maintaining safety programs and procedures to minimize on-the-job injuries and industrial health hazards. The safety programs and procedures vary from insured to insured. Depending upon the size, classifications and loss experience of the employer, our loss control department will periodically inspect the employer's place of business and may recommend changes that could prevent industrial accidents. In addition, severe or recurring injuries may also warrant on-site inspections. In certain instances, members of our loss control department may conduct special educational training sessions for insured employees to assist in the prevention of on-the-job injuries. For example, employers engaged in contracting may be offered a training session on general first aid and prevention of injuries from specific work exposures.

Competition

HMO and Managed Indemnity. Managed care companies and HMOs operate in a highly competitive environment. Our major competition is from self-funded employer plans, PPO networks, other HMOs, such as Nevada Care, Inc., Pacificare Health Systems, Inc., and Aetna and traditional indemnity carriers, such as Blue Cross/Blue Shield. Many of our competitors have substantially larger total enrollments, greater financial resources and offer a broader range of products. Additional competitors with greater financial resources may enter our markets in the future. We believe that the most important competitive factors are the delivery of reasonably priced, quality medical benefits to members and the adequacy and availability of health care delivery services and facilities. We depend on a large PPO network and flexible benefit plans to attract new members. Competitive pressures may result in reduced membership levels. Any reductions could materially affect our results of operations.

Workers' Compensation. Our workers' compensation business is concentrated in California, a state where the workers' compensation insurance industry is extremely competitive. When open rating became effective for policyholders in 1995, there were substantial reductions in premiums. Starting in the latter part of 1999 however, we and other carriers began increasing rates. In 2000 and 2001, we received increases on policies renewed in California of 26% and 38%, respectively. Based on public information, other California workers' compensation companies issued year 2001 policies at rates averaging 22% in excess of the expiring rates. For the first two months of 2002, the average renewal rate increase for our California policies was approximately 33%.

Approximately 160 companies wrote workers' compensation insurance in California in 2001, including the State Compensation Insurance Fund, which is the largest writer in California. Many of our competitors have been in business longer, have a larger volume of business, offer a more diversified line of insurance coverage and have greater financial resources and distribution capability than we do.

Losses and Loss Adjustment Expenses

In workers' compensation insurance, several years may elapse between the occurrence of a loss and the final settlement of the loss. To recognize liabilities for unpaid losses, we establish reserves, which are balance sheet liabilities representing estimates of future amounts needed to pay claims and related expenses for insured events, including reserves for events that have been incurred but not reported or IBNR.

When a claim is reported, our claims personnel initially establish reserves on a case-by-case basis for the estimated amount of the ultimate payment. These estimates reflect the judgment of the claims personnel based on their experience and knowledge of the nature and value of the specific type of claim and the available facts at the time of reporting as to severity of injury and initial medical prognosis. Included in these reserves are estimates of the expenses of settling claims, including legal and other fees. Claims personnel adjust the amount of the case reserves as the claim develops and as the facts warrant.

IBNR reserves are established for unreported claims and loss development relating to current and prior accident years. In the event that a claim that occurred during a prior accident year was not reported until the current accident year, the case reserve for the claim typically will be established out of previously established IBNR reserves for that prior accident year. Unallocated loss adjustment expense reserves are established for the estimated costs related to the general administration of the claims adjustment process.

The National Association of Insurance Commissioners requires that we submit a formal actuarial opinion concerning loss reserves with each statutory annual report. The annual report must be filed with each applicable state department of insurance on or before March 1st of the succeeding year. The actuarial opinion must be signed by a qualified actuary as determined by the applicable state insurance regulators. We retain the services of a qualified independent actuary to periodically review our loss reserves.

We review the adequacy of our reserves on a periodic basis and consider external forces including changes in the rate of inflation, the regulatory environment, the judicial administration of claims, medical costs and other factors that could cause actual losses and loss adjustment expenses, or LAE to change. Reserves are reviewed with our independent actuary at least annually and usually twice a year. The actuarial projections include a range of estimates reflecting the uncertainty of projections. We evaluate the reserves in the aggregate, based upon the actuarial indications, and make adjustments where appropriate. Our consolidated financial statements provide for reserves based on the anticipated ultimate cost of losses. We also supplement our analyses by comparing our paid losses and incurred losses to similar data provided by the Workers' Compensation Insurance Rating Bureau of California for all California workers' compensation insurance companies.

Government Regulation and Recent Legislation

HMOs and Managed Indemnity. Federal and state governments have enacted statutes that extensively regulate the activities of HMOs. Among the areas regulated by federal and state law are the scope of benefits available to members, grievances and appeals, prompt payment of claims, premium structure, procedures for review of quality assurance, enrollment requirements, the relationships between an HMO and its health care providers and members, licensing and financial condition.

Government concerns regarding increasing health care costs and quality of care could result in new or additional state or federal legislation that would impact health care companies, including HMOs, PPOs and other health insurers.

Government regulation of health care coverage products and services is a dynamic area of law that varies from jurisdiction to jurisdiction. Amendments to existing laws and regulations are continually being considered and interpretation of the existing laws and rules changes from time to time. Regulatory agencies generally exercise broad discretion in interpreting laws and promulgating regulations to enforce their interpretations.

While we are unable to predict what legislative or regulatory changes may occur or the impact of any particular change, our operations and financial results could be negatively affected by any legislative or regulatory requirements. For example, any proposals to eliminate or reduce the Employee Retirement Income Security Act, or ERISA, which regulates insured and self-insured health care coverage plans offered by employers, pre-emption of state laws that would increase litigation exposure, affect underwriting practices, limit rate increases, require new or additional benefits or affect contracting arrangements (including proposals to require HMOs and PPOs to accept any health care provider willing to abide by an HMO's or PPO's contract terms) may have a material adverse effect on our business. The continued consideration and enactment of "anti-managed care" laws and regulations by federal and state bodies may make it more difficult for us to manage medical costs and may adversely affect financial results.

The Secretary of the U.S. Department of Health and Human Services, or HHS, has established a committee on regulatory reform. This committee will help guide HHS' efforts to streamline unnecessarily burdensome and inefficient regulations for the Medicare and Medicaid populations, both of which we arrange services for under our managed care programs.

In addition to changes in existing laws and regulations, we are subject to audits, investigations and enforcement actions. These include possible government actions relating to ERISA, the Federal Employees Health Benefit Plan, federal and state fraud and abuse laws and laws relating to utilization management and the delivery and payment of health care. In addition, our Medicare business is subject to Medicare regulations promulgated by CMS. Violation of government laws and regulations may result in an assessment of damages, civil or criminal fines or penalties, or other sanctions, including exclusion from participation in government programs. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services.

There has been Congressional activity in Washington D.C. relative to Medicare and the Medicare+Choice programs. Unfortunately, Congress concluded the 2001 legislative session without taking final action on issues of importance to us, including increased funding for the Medicare+Choice programs and repeal or delay of the "lock-in" requirement.

The "lock-in" provisions become effective January 1, 2002. Under the "lock-in" provisions of the Medicare+Choice program, beneficiaries may elect plans (including other plans offered by a Medicare+Choice Organization (M+CO) or the original Medicare plan) only during the Annual Election Period (AEP) in November or once during the Open Enrollment Period (OEP) from January through the end of June. Starting in 2003, the OEP extends only from January through the end of March. With a few exceptions, a Medicare beneficiary cannot enroll in or disenroll from a Medicare+Choice plan, or return to the original Medicare plan, at any other time of the year.

We have HMO licenses in Nevada, Texas and Arizona. Our HMO operations are

subject to regulation by the Nevada Division of Insurance, the Nevada State Board of Health, the Texas Department of Insurance and the Arizona Department of Insurance. In May 2001, we terminated our HMO operations in Arizona and filed a withdrawal plan with the Department of Insurance in Texas to terminate our Texas HMO operations effective on April 17, 2002 for business reasons. As part of the withdrawal plan from Texas, we terminated our CMS Medicare+Choice and Federal Employees Health Benefits Program contracts at the end of 2001.

Our HMOs are federally qualified under the Federal HMO Act and are subject to the Act and its regulations. In order to obtain federal qualification, an HMO must, among other things, provide its members certain services on a fixed, prepaid fee basis and set its premium rates in accordance with certain rating principles established by federal law and regulation. The HMO must also have quality assurance programs in place with respect to our health care providers. Furthermore, an HMO may not refuse to enroll an employee, in most circumstances, because of a person's health, and may not expel or refuse to re-enroll individual members because of their health or their need for health services.

Our managed indemnity health insurance subsidiary is domiciled and incorporated in California and is licensed in 43 states and the District of Columbia. It is subject to licensing and other regulations of the California Department of Insurance as well as the insurance departments of the other states in which it operates or holds licenses.

Our HMO and health insurance subsidiary insurance premium rate increases are subject to various state insurance department approvals.

Our Nevada HMO and managed indemnity health insurance subsidiary currently maintain a home office and a regional home office, respectively, in Las Vegas and, accordingly, are eligible for certain premium tax credits in Nevada. We intend to take all necessary steps to continue to comply with eligibility requirements for these credits. The elimination or reduction of the premium tax credit would have a material adverse effect on our results of operations.

Under the "corporate practice of medicine" doctrine, in most states, business organizations, other than those authorized to do so, are prohibited from providing, or holding themselves out as providers of, medical care. Some states, including Nevada, exempt HMOs from this doctrine. The laws relating to this doctrine are subject to numerous conflicting interpretations. Although we seek to structure our operations to comply with corporate practice of medicine laws in all states in which we operate, there can be no assurance that, given the varying and uncertain interpretations of those laws, we would be found to be in compliance with those laws in all states. A determination that we are not in compliance with applicable corporate practice of medicine laws in any state in which we operate could have a material adverse effect on us if we were unable to restructure our operations to comply with the laws of that state.

Certain Medicare and Medicaid antifraud and abuse provisions are codified at 42 U.S.C. Sections 1320a-7(b) (the Anti-kickback Statute) and 1395nn (the Stark Amendments). Many states have similar anti-kickback and anti-referral laws. These statutes prohibit certain business practices and relationships involving the referral of patients for the provision of health care items or services under certain circumstances. Violations of the Anti-kickback Statute and the Stark Amendments may result in criminal penalties, civil sanctions, fines and possible exclusion from the Medicare, Medicaid and other federal health care programs. Similar penalties are provided for violation of state anti-kickback and anti-referral laws. HHS has issued regulations establishing and defining "safe harbors" with respect to the Anti-kickback Statute and the Stark Amendments. We believe that our business arrangements and operations are in compliance with the Anti-kickback Statute and the Stark Amendments as defined by the relevant safe harbors. However, there can be no assurance that (i) government officials charged with responsibility for enforcing the prohibitions

of the Anti-kickback Statute and the Stark Amendments or Qui Tam relators purporting to act on behalf of the Government will not assert that we, or certain conduct in which we are involved, are in violation of those statutes; and (ii) such statutes will ultimately be interpreted by the courts in a manner consistent with our interpretation.

We participate in a consortium of health plans whose work includes seeking legislative permanency for the Social HMO programs. The Social HMO is a Medicare+Choice demonstration program that enables our Nevada HMO to offer extended benefits to seniors will expire at the end of 2003. The majority of our Medicare members are enrolled in the Social HMO program and the discontinuation of the program may negatively impact our operating results or financial condition.

The Federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, contains provisions that impact us and will require operational changes as various federal departmental regulations required by the Act are promulgated. With certain conditions imposed, the compliance date of the regulation that establishes standards for electronic transactions and code sets has been delayed one year to October 1, 2003. One of the conditions of the delay is that health plans must request an extension of time by filing a summary report of their implementation plans with HHS by October 16, 2002. We intend on requesting an extension of time by filing a summary report prior to the October deadline. The health information privacy rule component of HIPAA requires compliance by April 14, 2003.

Work is underway to meet the requirements of all HIPAA related regulations impacting us. Failure to comply with the standards and implementation specifications of HIPAA regulations could result in investigation by the Office of Civil Rights of HHS and the imposition of criminal penalties and civil sanctions, including fines. At this time, we cannot quantify the cost of compliance or the impact it will have on our business. There can be no assurance that the costs to implement and to comply will not adversely affect our operating results or financial condition.

In November 2000, the Department of Labor published the final regulation on ERISA claims procedures, the first major revision of the existing claims procedure requirements since 1977. The regulation applies to all employee benefit plans governed by ERISA, whether the benefits are provided through insurance products or are self-funded. This regulation impacts our third party administrator services and potentially other operations and will apply to all claims filed on or after January 1, 2002.

Workers' Compensation. We are subject to extensive governmental regulation and supervision in each state in which we conduct workers' compensation business. The primary purpose of the regulation and supervision is to provide safeguards for policyholders and injured workers rather than protect the interests of shareholders. The extent and form of the regulation may vary, but generally it has its source in statutes that establish regulatory agencies and delegate to the regulatory agencies broad regulatory, supervisory and administrative authority. Typically, state regulations extend to matters such as licensing companies; restricting the types or quality of investments; requiring triennial financial examinations and market conduct surveys of insurance companies; licensing agents; regulating aspects of a company's relationship with its agents; restricting use of some underwriting criteria; regulating premium rates, forms and advertising; limiting the grounds for cancellation or nonrenewal of policies; solicitation and replacement practices; and specifying what might constitute unfair practices.

Typically, states mandate participation in insurance guaranty associations, which assess solvent insurance companies in order to fund claims of policyholders of insolvent insurance companies. Under this arrangement, insurers

can be assessed up to 1%, or 2% in certain states, of premiums written for workers' compensation insurance in that state each year to pay losses and LAE on covered claims of insolvent insurers. In certain states, insurance companies are allowed to recoup such assessments from policyholders while several states allow an offset against premium taxes. In California, insurance companies are required to recoup guaranty fund assessments from policyholders. California assessments are recorded as an asset and all other assessments are expensed as incurred.

Starting in 2000, the California Insurance Guarantee Association, or CIGA, issued assessments as a result of the insolvency of the insurers owned by Superior National Insurance Group and other insolvent workers' compensation insurance companies. The assessments are initially made on direct premiums written reported in the prior year and are subsequently adjusted to the actual direct premiums written in the following year. For example, CIGA issued an assessment in 2000 using the 1999 direct premiums written as the initial assessment. We began recouping the assessment on policies effective January 1, 2001. Our initial assessment will be adjusted to our actual premiums written in 2001. Any difference between the actual and initial premiums written would be either refunded to the member insurer, in the case of lower actual premiums, or an additional assessment imposed, in the case of higher actual premiums. In addition, any excess assessments that we recoup would have to be paid to CIGA. The CIGA assessments are recorded as an asset, which is reduced as we recoup the assessments. On an on-going basis, we evaluate the asset for impairment. In 2000, CIGA assessed us 1% of the 1999 direct premiums written for $1.2 million. In 2001, CIGA assessed us 2% of the 2000 direct premiums written for $3.1 million. In January 2002, CIGA assessed an additional 2% of the 2000 direct written premiums for $3.1 million. These assessments are being recouped starting with policies effective January 1, 2001 through December 31, 2003.

There were no assessments by non-California states in 2000 and total assessments by all other states were less than $300,000 in 2001. It is likely that guarantee fund assessments related to insolvent workers' compensation insurance companies will continue for the next several years.

General. Besides state insurance laws, we are subject to general business and corporation laws, federal and state securities laws, consumer protection laws, fair credit reporting acts and other laws regulating the conduct and operation of our subsidiaries.

In the normal course of business, we may disagree with various government agencies that regulate our activities on interpretations of laws and regulations, policy wording and disclosures or other related issues. These disagreements, if left unresolved, could result in administrative hearings and/or litigation. We attempt to resolve all issues with the regulatory agencies, but are willing to litigate issues where we believe we have a strong position. The ultimate outcome of these disagreements could result in sanctions and/or penalties and fines assessed against us. Currently, there are no litigation matters pending with any government agencies.

Deposits. Our HMO and insurance subsidiaries are required by state regulatory agencies to maintain certain deposits and must also meet certain net worth and reserve requirements. The HMO and insurance subsidiaries had restricted assets on deposit in various states totaling $26.0 million at December 31, 2001. The HMO and insurance subsidiaries must also meet requirements to maintain minimum stockholders' equity, on a statutory basis, as well as minimum risk-based capital requirements, which are determined annually. Additionally, in conjunction with the Kaiser-Texas acquisition, TXHC entered into a letter agreement with the Texas Department of Insurance whereby TXHC agreed to maintain a net worth of $20.0 million, on a statutory basis, until certain income levels are achieved. In conjunction with the exit from the Texas HMO health care market, the Texas Department of Insurance approved a plan of withdrawal and TXHC is now required to maintain deposits and net worth of $3.5 million. We believe

we are in compliance with our regulatory requirements.

Dividends. Our HMO and insurance subsidiaries are restricted by state law as to the amount of dividends or distributions that can be declared and paid. Moreover, insurance companies and HMOs domiciled in Texas, Nevada and California generally may not pay extraordinary dividends or distributions without providing the state insurance commissioner with 30 days prior notice, during which period the commissioner may disapprove the payment. An "extraordinary dividend or distribution" is generally defined as a dividend or distribution whose fair market value together with that of the other dividends or distributions made within the preceding 12 months exceeds the greater of (i) ten percent of the insurer's surplus as of the preceding December 31 or (ii) net gain from operations of an insurer, if a life insurer, or net income if not a life insurer, for the 12-month period ending on the preceding December 31.

In addition, our California domiciled insurance subsidiaries may not pay a dividend without the prior approval of the state insurance commissioner to the extent the cumulative amount of dividends or distributions paid or proposed to be paid in any year exceeds the amount shown as unassigned funds (reduced by any unrealized gains included in any such amount) on the insurer's statutory statement as of the previous December 31.

In 2001, California Indemnity Insurance Company received prior approval to pay an aggregate of $10 million in dividends, all of which was used to purchase or retire the subordinated debentures.

We are not in a position to assess the likelihood of obtaining future approval for the payment of dividends other than those specifically allowed by law in each of our subsidiaries' state of domicile.

No prediction can be made as to whether any legislative proposals relating to dividend rules in the domicilliary states of our subsidiaries will be made or adopted in the future, whether the insurance departments of such states will impose either additional restrictions in the future or a prohibition on the ability of our regulated subsidiaries to declare and pay dividends or as to the effect of any such proposals or restrictions on our regulated subsidiaries.

Employees

We had approximately 3,600 employees as of March 15, 2002. None of our employees are covered by a collective bargaining agreement. We believe that our relations with our employees are good.

Note on Forward-Looking Statements and Risk Factors

Forward-Looking Statements

This annual report on Form 10-K contains "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, both as amended.

The forward looking statements regarding Sierra Health Services, Inc.'s business and results of operations should be considered by our stockholders or any reader of our business or financial information along with the risk factors discussed below. All statements other than statements of historical fact are forward-looking statements for purposes of federal and state securities laws. The cautionary statements are made pursuant to the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995, as amended, and identify important factors that could cause our actual results to differ materially from those expressed in any projected, estimated or forward-looking statements relating to us. These forward-looking statements are identified by their use of terms and phrases such as "anticipate," "believe," "could," "estimate,"

"expect," "hope," "intend," "may," "plan," "predict," "project," "seeks," "will," "continue," and other similar terms and phrases, including references to assumptions. Such forward-looking statements may be contained in the sections "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Business," among other places.

Although we believe that the expectations reflected in any of our forward-looking statements are reasonable, actual results could differ materially from those projected or assumed in any of our forward-looking statements.

In making these statements, we disclaim any intention or obligation to address or update each factor in future filings or communications regarding our business or results, and we do not undertake to address how any of these factors may have caused changes to discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected our past results and may affect future results, so that our actual results may differ materially from those expressed here and in prior or subsequent communications.

We urge you to review carefully the section below, "Risk Factors," in this 2001 Form 10-K for a more complete discussion of the risks associated with an investment in our securities.

Risk Factors

We are exiting the Texas health care market and we will cease providing coverage on April 17, 2002. We have recorded reserves and accrued expenses for all anticipated exit-related costs but unanticipated expenses could result in additional losses during the run-out period.

We are exiting the Texas health care market and will stop providing health care services on April 17, 2002. Unanticipated expenses, primarily related to legal matters and provider settlements, could result in additional losses. In addition, we are limited by our credit facility in the amount of funds we can provide to our Texas health care operations. Should we exceed our limits, then we would need approval by our banks to waive or amend this covenant or we would be in default.

A variety of factors beyond our control could affect our results of operations. Our results of operations can be adversely affected by the following:

- Loss of health care premium and workers' compensation insurance premium revenues due to heightened competition;
- Inadequate premium revenues due to heightened competition, miscalculations of underlying healthcare and workers' compensation costs and other factors in our rate filings and in underwriting accounts;
- Significant reductions in retaining accounts and members;
- Inability or delays in making timely changes to health care benefits to offset the impact of inadequate premium rates;
- Loss of Medicare, Medicaid or TRICARE contracts;
- Inability to timely and fairly negotiate TRICARE change orders or contract bid price adjustments with the Department of Defense;
- Inability to effectively manage the TRICARE contract and our at-risk members;

- Loss of or significant changes in our health care provider contracts;
- Inability or unwillingness of our contracted providers to provide health care services to our members;
- Significantly higher costs of medical malpractice insurance, reduced coverage that increases our risk exposure or the unavailability of coverage that either affect us or our contracted providers;
- Terrorist acts that directly affect the operation of our business or our customers, policyholders and members;
- A sustained and severe economic recession, especially in Nevada or California;
- Adverse loss development on healthcare payables and workers' compensation insurance reserves resulting from unanticipated increases or changes in our claims costs;
- Inability or unwillingness of our reinsurers to honor their contractual obligations;
- Adverse legal judgments that are not covered by insurance or that indirectly impact our ability to obtain insurance in the future at reasonable costs;
- Significant declines in investment rates;
- New legislation, regulations or their interpretations, including the impact of new legislation enacted in California in 2002 that will increase benefits to injured workers starting January 1, 2003, which increase our costs and exposure to lawsuits without a corresponding increase in revenues;
- Inability to implement HIPAA privacy rules on a timely, accurate and cost effective basis;
- A ratings downgrade from insurance rating agencies, such as A.M. Best Company and Fitch Ratings, and from health care quality rating organizations, such as the National Committee for Quality Assurance;
- Inability to maintain or enhance, as required, our management information systems;
- Inability to expand our e-business initiatives on a timely basis and in compliance with government regulations; or
- Power interruptions in California, where our workers' compensation operations' main computer systems reside.

Our reinsurance costs may significantly increase or coverage may be limited, which could adversely impact us.

Due to the September 11, 2001 terrorist acts, the reinsurance market has contracted and reinsurance premium rates have significantly increased. We also expect that reinsurers will try to limit their future exposure to terrorist acts. If we are unable to adequately increase our premiums to cover the anticipated increase in our reinsurance costs or the increase in risk exposure, our operating results and financial condition may be materially affected.

If we are unable to comply with the terms of our credit facility, our borrowing

costs could increase and if we cannot refinance or pay the outstanding indebtedness under the credit facility at maturity, our business could be adversely affected.

We entered into an amended $185 million credit facility with the banks on December 15, 2000, and this credit facility is guaranteed by our subsidiaries. As of December 31, 2001, the outstanding balance under our credit facility was $89 million and the credit facility limit was reduced to $117 million. The total availability will be reduced by $6.0 million on June 30, 2002 and December 31, 2002 and finally by $10.0 million on June 30, 2003. There is no assurance that we will be able to obtain future waivers if we are unable to meet the covenant requirements or to cure a default on a timely basis. Failure to obtain a waiver or to cure a default on a timely basis could result in significantly higher borrowing costs and/or a demand for payment of the principal. The credit facility matures on September 30, 2003 and there is no assurance that we can successfully refinance or pay this debt when it matures. In addition, the loans bear interest at a fluctuating rate, which could result in significantly higher borrowing costs.

We are limited under our credit facility in the amount of funds we can transfer to our discontinued Texas HMO health care operations. If we transfer more funds during the run-out period then we are allowed, we would be out of compliance with our credit facility. If additional funds are needed by our discontinued Texas HMO health care operations and we do not transfer such funds, they may be in violation of certain insurance regulations.

Under the terms of our credit facility agreement, after September 30, 2001 we can invest an additional $5.0 million in the Texas operations and replace the Texas real estate assets with cash and notes up to $46 million. Under the terms of the amended and restated agreement, the use of Sierra funds to pay the outstanding Texas mortgage note of $29.2 million is not considered an investment in the Texas operations. During the fourth quarter of 2001, we invested in Texas the full $5.0 million allowed under the amended and restated agreement. If we had to invest more than we are allowed, we would be required to get a waiver or an amendment to our agreement or be out of compliance. If additional funds are needed by our discontinued Texas HMO health care operations and we do not transfer such funds, they may be in violation of certain insurance regulations and we may be required to get a waiver or an amendment to our agreement or be out of compliance. There is no assurance that if we needed a bank waiver or amendment that we would be able to obtain it. Failure to obtain a waiver or amendment could result in significantly higher borrowing costs and/or a demand for payment of the principal.

If we fail to qualify for the Nevada home office tax credit, our tax costs will increase.

Under existing Nevada law, a 50% premium tax credit is generally available to HMOs and insurers that own and substantially occupy home offices or regional home offices within Nevada. In connection with the settlement of a prior dispute concerning the premium tax credit, the Nevada Department of Insurance acknowledged in November 1993 that our HMO and insurance subsidiaries met the statutory requirements to qualify for this tax credit. We intend to take all necessary steps to continue to comply with these requirements. The elimination or reduction of the premium tax credit, or our failure to qualify for the premium tax credit, would have a material adverse effect on our results of operations.

We depend on our management for our success and the loss of our founder, Chairman of the Board and Chief Executive Officer could have a material adverse effect on our business.

Our success has been dependent to a large extent upon the efforts of Anthony M.

Marlon, M.D., our founder, Chairman of the Board and Chief Executive Officer, who has an employment agreement with us. Although we believe that the development of our management staff has made us less dependent on Dr. Marlon, the loss of Dr. Marlon could still have a material adverse effect on our business.

The price of our common stock has been volatile and we cannot assure you as to the price at which our common stock will trade in the future.

There has been significant volatility in the market prices of securities of companies in the health care industry, including the price of our common stock. Many factors, including medical cost increases, research analysts' comments, announcements of new legislative and regulatory proposals or laws relating to health care reform, investor expectations, the trading volume of our common stock, litigation and general economic and market conditions, will influence the trading price of our common stock.

ITEM 2. DESCRIPTION OF PROPERTIES

On December 28, 2000, we finalized a sale-leaseback transaction that included the majority of our administrative and clinical properties in Las Vegas totaling approximately 478,000 square feet. The lease is for a term of fifteen years and we have the option of five 5-year renewal periods. We lease additional office and clinical space in Nevada totaling approximately 142,000 and 36,000 square feet, respectively. HPN and SHL have retained ownership of a 134,000 square foot administrative building at their Las Vegas headquarters, which serves as the home office and a regional home office for our Nevada HMO and health insurance subsidiaries, respectively.

In conjunction with the Kaiser-Texas acquisition, we purchased eight medical and office facilities with approximately 323,000 square feet of clinical facilities and approximately 175,000 square feet of administrative facilities. These buildings are subject to a deed of trust note with an original balance of $35.2 million and a remaining principal balance of $22.7 million at December 31, 2001. Approximately 47,000 square feet of the clinical and 60,000 square feet of the administrative space are leased by outside parties. The Texas assets have been written down to market value and are included in the assets of discontinued operations. We are actively seeking a buyer for the assets and anticipate selling them by the end of 2002.

The workers' compensation subsidiary is headquartered in Nevada and subleases space from us in one of the buildings included in the sale-leaseback transaction as well as an additional approximately 75,000 square feet of leased office space in California, Colorado and Texas.

We lease approximately 125,000 square feet of office space in other various states as needed for the military subsidiary's administrative headquarters, TRICARE service centers and other regional operations.

We believe that current and planned clinical space will be adequate for our present needs. However, additional clinical space may be required if membership expands in southern Nevada.

ITEM 3. LEGAL PROCEEDINGS

We are subject to various claims and other litigation in the ordinary course of business. Such litigation includes, for example, claims of medical malpractice, claims for coverage or payment for medical services rendered to HMO members and insureds and claims by providers for payment for medical services rendered to HMO members. Also included in such litigation are claims for workers' compensation and claims by providers for payment of medical services rendered to injured workers. In the opinion of our management, the ultimate resolution of

pending legal proceedings should not have a material adverse effect on our financial condition or results of operations.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

None

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

Market Information

Our common stock, par value $.005 per share (the "Common Stock"), has been listed on the New York Stock Exchange under the symbol SIE since April 26, 1994 and, prior to that, had been listed on the American Stock Exchange since our initial public offering on April 11, 1985. The following table sets forth the high and low sales prices for the Common Stock for each quarter of 2001 and 2000.

Period	High
2001	
First Quarter	$ 6.70
Second Quarter	7.04
Third Quarter	10.97
Fourth Quarter	9.75
2000	
First Quarter	$ 8.25
Second Quarter	5.13
Third Quarter	4.75
Fourth Quarter	6.00

On March 18, 2002, the closing sale price of Common Stock was $11.62 per share.

Holders

The number of record holders of Common Stock at March 15, 2002 was 211. Based upon information available to us, we believe there are approximately 6,200 beneficial holders of the Common Stock.

Dividends

No cash dividends have been paid on the Common Stock since our inception. We currently intend to retain our earnings for use in our business and do not anticipate paying any cash dividends in the foreseeable future. As a holding company, our ability to declare and to pay dividends is dependent upon cash distributions from our operating subsidiaries. The ability of our HMOs and our insurance subsidiaries to declare and pay dividends is limited by state regulations applicable to the maintenance of minimum deposits, reserves and net worth. The declaration of any future dividends will be at the discretion of our Board of Directors and will depend on, among other things, future earnings, debt covenants, operations, capital requirements, our financial condition and general business conditions.

ITEM 6. SELECTED FINANCIAL DATA

The table below presents our selected consolidated financial information for the years indicated. The table should be read in conjunction with the Consolidated Financial Statements and the related Notes thereto, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and other information which appears elsewhere in this 2001 Form 10-K. The selected consolidated financial data below has been derived from our audited Consolidated Financial Statements.

	Years Ended		
	2001	2000	19
		(In thousands, ex	
Statements of Operations Data:			
OPERATING REVENUES:			
Medical Premiums	$ 718,994	$ 637,769	$ 594
Military Contract Revenues	338,918	330,352	287
Specialty Product Revenues	183,306	135,844	94
Professional Fees	28,985	33,102	42
Investment and Other Revenues	21,298	22,513	20
Total	1,291,501	1,159,580	1,039
OPERATING EXPENSES:			
Medical Expenses	608,757	576,738	534
Military Contract Expenses	331,621	323,265	276
Specialty Product Expenses	188,574	152,733	96
General, Administrative and Marketing Expenses	117,717	105,314	94
Asset Impairment, Restructuring, Reorganization and Other Costs (1)		33,836	7
Total	1,246,669	1,191,886	1,009
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	44,832	(32,306)	29
INTEREST EXPENSE AND OTHER, NET	(18,563)	(19,362)	(16
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	26,269	(51,668)	12
(PROVISION) BENEFIT FOR INCOME TAXES	(8,803)	12,875	(2
NET INCOME (LOSS) FROM CONTINUING OPERATIONS	17,466	(38,793)	10
LOSS FROM DISCONTINUED OPERATIONS	(13,980)	(161,122)	(15
NET INCOME (LOSS)	$ 3,486	$ (199,915)	$ (4
EARNINGS PER COMMON SHARE (2):			
Net Income (Loss) From Continuing Operations	$0.63	$(1.43)	$

Loss from Discontinued Operations	(0.50)	(5.94)	(
Net Income (Loss)	$0.13	$(7.37)	$(
Weighted Average Number of Common Shares Outstanding	27,685	27,142	26
EARNINGS PER COMMON SHARE ASSUMING DILUTION (2):			
Net Income (Loss) From Continuing Operations	$0.61	$(1.43)	$
Loss from Discontinued Operations	(0.49)	(5.94)	(
Net Income (Loss)	$0.12	$(7.37)	$(
Weighted Average Number of Common Shares Outstanding Assuming Dilution	28,509	27,142	26

	2001	2000	De (In
Balance Sheet Data:			
Working Capital	$ 106,119	$ 78,317	$
Total Assets	1,069,962	1,165,100	
Long-term Debt (Net of Current Portion)	181,759	224,970	
Cash Dividends Per Common Share	none	none	
Stockholders' Equity	96,519	90,473	

(1) We recorded certain identifiable asset impairment, restructuring, reorganization and other costs. See Note 17 of Notes to the Consolidated Financial Statements.

(2) Adjusted to account for three-for-two stock split of our common stock to stockholders of record as of May 18, 1998.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis provides information which management believes is relevant for an assessment and understanding of our consolidated financial condition and results of operations. The discussion should be read in conjunction with the Consolidated Financial Statements and related Notes thereto. The information contained below may be subject to risk factors. We urge you to review carefully the section "Risk Factors" in this 2001 Form 10-K for a more complete discussion of the risks associated with an investment in our securities. See "Note on Forward-Looking Statements and Risk Factors" under Item 1.

Overview

We derive revenues from our health maintenance organizations, managed indemnity, military health care services and workers' compensation insurance subsidiaries. To a lesser extent, we also derive additional specialty product revenues from non-HMO and insurance products (consisting of fees for workers' compensation administration, utilization management services and ancillary products), professional fees (consisting primarily of fees for providing health care services to non-members and co-payment fees received from members), and investment and other revenue.

Our principal expenses consist of medical expenses, military contract expenses, specialty product expenses, and general, administrative and marketing expenses. Medical expenses represent capitation fees and other fee-for-service payments paid to independently contracted physicians, hospitals and other health care providers to cover members, as well as the aggregate expenses to operate and manage our wholly owned multi-specialty medical group and other provider subsidiaries. As a provider of health care management services, we seek to positively affect quality of care and expenses by contracting with physicians, hospitals and other health care providers at negotiated price levels, by adopting quality assurance programs, monitoring and managing utilization of physicians and hospital services and providing incentives to use cost-effective providers. Military contract expenses represent payments to providers for health care services rendered under the TRICARE program, as well as administrative costs to operate the military health care subsidiary. Specialty product expenses primarily consist of losses and loss adjustment expenses, policy acquisition expenses and other general and administrative expenses associated with our workers' compensation insurance subsidiaries. General, administrative and marketing expenses generally represent operational costs other than those directly associated with the delivery of health care services, military contract services and specialty products.

Texas HMO Health Care Operations

During 2001, we made significant premium rate increases on renewing membership in our Texas HMO health care operations. In the third quarter, we embarked on a recontracting effort to reduce medical costs. It was during this recontracting effort that unsustainable cost increases were revealed, including the operation's primary hospital contract. Although considerable efforts were made to achieve profitability in Texas, it was determined that under the current operating environment, we would not be able to turn around the operating results. At the end of the third quarter, we announced a plan to exit the Texas HMO health care market and subsequently recorded exit-related charges of $17.1 million. We received formal approval from the Texas Department of Insurance to withdraw our operations and we will cease providing HMO health care coverage in Texas on April 17, 2002. In accordance with SFAS No. 144, the Texas HMO health care operations have been reclassified as discontinued operations.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Critical Accounting Policies and Estimates

Our consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America. In preparing these financial statements, we are required to make judgments, assumptions and estimates, which we believe are reasonable and prudent based on the available facts and circumstances. These judgments, assumptions and estimates affect certain of our revenues and expenses and their related balance sheet accounts and in disclosing our contingent assets and liabilities. We base our assumptions and estimates primarily on historical experience and trends and

factor in known and projected trends. On an on-going basis, we re-evaluate our selection of assumptions and the method of calculating our estimates. Actual results, however, may differ from our calculated estimates and this difference would be reported in our current operations. The following discusses our most critical accounting policies and estimates.

Military contract revenue is recorded based on the contract price as agreed to by the federal government. The contract was based on prior years' data provided by the government along with assumptions of future trends. The contract contains provisions that adjust the contract price based on actual experience, which we call the bid price adjustment, or BPA, and for government-directed change orders. As the data becomes available from the government, we compare the actual results to the contract assumptions and the estimated effects of these adjustments are recognized on a monthly basis. In addition, we record revenue based on estimates of the earned portion of any contract change orders not originally specified in the contract. The BPA and government-directed change orders are subject to negotiation and we must use our judgment in making our estimates. The actual negotiated price could be substantially different from what we had originally estimated. Any difference would be reported in current operations.

Military contract health care costs are recorded in the period when services are provided to eligible beneficiaries, including estimates for provider costs which have been incurred as of the balance sheet date but not reported to us. We use a variety of actuarial projection methods to make these estimates and we must use our judgment in selecting development factors and assumed trends. Our assumptions, which are in large part related to the same assumptions we use in estimating military contract revenues, could be affected by unanticipated changes, such as new interpretations of contract provisions that result in our having to provide new or extended benefits and changes in our health care delivery system or costs. We must also factor into our assumptions the limited risk sharing that we have with the government in providing health care services. Any substantial errors in our estimates are to a large degree mitigated by the risk-sharing contract provision. Any subsequent changes in an estimate for a prior year would be reflected in the current year's operating results.

Health care medical expenses are recorded in the period when services are provided to enrolled members, including estimates for provider costs which have been incurred as of the balance sheet date but not yet reported to us. We use a variety of actuarial projection methods to make these estimates and we must use our judgment in selecting development factors and assumed trends. Our assumptions could be affected by unanticipated changes, such as adverse legal outcomes, legislative or regulatory changes, new interpretations of existing laws or regulations or disputed contract provisions that result in our having to provide new or extended benefits and changes in our health care delivery system or costs. Any subsequent changes in an estimate for a prior year would be reflected in the current year's operating results.

Specialty product workers' compensation insurance losses and loss adjustment expenses, or LAE, are based upon the accumulation of cost estimates for reported claims occurring during the period as well as an estimate for losses that have occurred but have not yet been reported. Similar to the health care medical expenses, we use a variety of actuarial projection methods to make these estimates and we must use our judgment in selecting development factors and assumed trends. Unlike health care medical expenses, where the cost to provide health care services is substantially completed within one year, workers' compensation claims can be paid out over a substantial number of years due to certain lifetime benefits. In addition, the period between when a claim is reported to us and when the injury occurred could be longer than one year and when we are no longer insuring the account. Loss and LAE reserves have a significant degree of uncertainty when related to their subsequent payments. Although our reserves are established on the basis of a reasonable estimate, it

is not only possible but probable that our reserves will differ from their related subsequent developments. Underlying causes for this uncertainty include, but are not limited to, uncertainty in development patterns, unanticipated inflationary trends affecting the services covered by the insurance contract, adverse legal outcomes and new interpretations of laws or regulations or of disputed contract provisions that result in our having to provide new or extended benefits. This uncertainty can result in both adverse as well as favorable development of actual subsequent activity when compared to the reserve established. Any subsequent change in loss and LAE reserves established in a prior year would be reflected in the current year's operating results.

Reinsurance recoverable primarily represents the estimated amount of unpaid workers' compensation loss and LAE reserves that would be recovered from our reinsurers and, to a lesser extent, amounts billed to the reinsurers for their portion of paid losses and LAE and health care claims. Reinsurance receivable for ceded paid claims is recorded in accordance with the terms of the agreements and reinsurance recoverable for unpaid losses and LAE and medical claims payable is estimated in a manner consistent with the claim liability associated with the reinsurance policy. Any significant changes in the underlying claim liability could directly affect the amount of reinsurance recoverable. Reinsurance recoverable, including amounts related to paid and unpaid losses, are reported as assets rather than a reduction of the related liabilities. Reinsurance contracts do not relieve us from our obligations to enrollees, injured workers or policyholders. If our reinsurers were to fail to honor their obligations because of insolvency or disputed contract provisions, we could incur significant losses. We evaluate the financial condition of our reinsurers to minimize our exposure to significant losses from reinsurer insolvencies.

Deferred income tax assets and liabilities result from temporary differences between the tax basis of assets and liabilities and the reported amounts in the consolidated financial statements that will result in taxable or deductible amounts in future years. Our temporary differences arise principally from certain net operating losses, accrued expenses, reserves that are discounted for tax return purposes, depreciation and impairment charges. We regularly review our deferred tax assets for recoverability based on historical taxable income, projected future taxable income and the expected timing of the reversals of the existing temporary differences.

In addition to the most critical accounting policies and estimates discussed above, other areas requiring us to use judgment, assumptions and estimates include, but are not limited to, allowance for retroactive health care premium revenue adjustments, workers' compensation earned but unbilled premiums, contractual discounts on professional fee revenue, allowances for doubtful receivables, litigation and legal settlement costs and accruals, other accrued liabilities, accrued payroll and taxes, unearned premium revenue and contingent assets and liabilities.

For a more extensive discussion of our accounting policies, see Note 2, Summary of Significant Accounting Policies, in the Notes to the Consolidated Financial Statements. Review the section "Risk Factors" in this 2001 Form 10-K for a more complete discussion of the risks associated with an investment in our securities.

Results of Operations

The following table sets forth selected operating data as a percentage of revenues for the periods indicated:

Years Ended December

	2001	2000
OPERATING REVENUES:		
Medical Premiums	55.7%	55.0%
Military Contract Revenues	26.2	28.5
Specialty Product Revenues	14.2	11.7
Professional Fees	2.2	2.9
Investment and Other Revenues	1.7	1.9
Total	100.0	100.0
OPERATING EXPENSES:		
Medical Expenses	47.1	49.7
Military Contract Expenses	25.7	27.9
Specialty Product Expenses	14.6	13.2
General, Administrative and Marketing Expenses	9.1	9.1
Asset Impairment, Restructuring, Reorganization and Other Costs		2.9
Total	96.5	102.8
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	3.5	(2.8)
INTEREST EXPENSE AND OTHER, NET	(1.4)	(1.7)
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	2.1	(4.5)
(PROVISION) BENEFIT FOR INCOME TAXES	(0.7)	1.2
NET INCOME (LOSS) FROM CONTINUING OPERATIONS	1.4	(3.3)
LOSS FROM DISCONTINUED OPERATIONS	(1.1)	(13.9)
NET INCOME (LOSS)	0.3%	(17.2)%

Year Ended December 31, 2001 Compared to 2000

Total Operating Revenues for 2001 increased approximately 11.4% to $1.29 billion from $1.16 billion for 2000. Medical premium revenues accounted for approximately 55.7% and 55.0% of our total revenues for the years ended December 31, 2001 and 2000, respectively.

The change in operating revenues was comprised of the following:

- An increase in medical premiums of $81.2 million
- An increase in military contract revenues of $8.6 million
- An increase in specialty product revenues of $47.5 million

- A decrease in professional fees of $4.2 million
- A decrease in investment and other revenues of $1.2 million

Medical Premiums from our HMO and managed indemnity insurance subsidiaries increased $81.2 million or 12.7%. The $81.2 million increase in premium revenue reflects a 7.9% increase in Medicare member months (the number of months individuals are enrolled in a plan) and a 10.9% increase in commercial member months. The growth in Medicare member months contributes significantly to the increase in premium revenues as the Medicare per member premium rates are over three times higher than the average commercial premium rate. HMO premium rates for commercial groups increased approximately 6.6%, managed indemnity rates increased approximately 14.6% and Medicare rates increased approximately 4.0%. Over 97% of our Las Vegas, Nevada Medicare members are enrolled in the Social HMO Medicare program. The Centers for Medicare and Medicaid Services, or CMS, formerly known as the Health Care Financing Administration, or HCFA, may consider adjusting the reimbursement factor or changing the program for the Social HMO members in the future. If the reimbursement for these members decreases significantly and related benefit changes are not made timely, there could be a material adverse effect on our business. Continued medical premium revenue growth is principally dependent upon continued enrollment in our products and upon competitive and regulatory factors.

Military Contract Revenues increased $8.6 million or 2.6%. The increase in revenue is primarily the result of additive change order work and is significantly offset by increased military contract expenses associated with those change orders. The Congressionally approved DoD fiscal year 2001 budget included several sweeping changes to the TRICARE program. In April 2001, SMHS began implementation of a prescription drug program for beneficiaries over age 65 and the implementation of a waiver of co-payments for active duty family members. Both of these program modifications resulted from Congressional changes to the program. Likewise, in October 2001, SMHS implemented TRICARE for Life which is a comprehensive health care benefit to those retired military beneficiaries over age 65. SMHS only administers the expanded benefits to the over age 65 retiree military population. SMHS does not directly fund claims payment or bear any risk for the actual level of health care service utilization. Revenues associated with these new programs will carry forward into 2002.

If all five option periods of the contract with the DoD are exercised and no extensions of the performance period are made, health care delivery will end on May 31, 2003, followed by an additional eight month phase out of the Region 1 managed care support contract. The DoD has extended expiring TRICARE contracts in other regions and SMHS has recently begun negotiations with the DoD about a possible extension to the base contract.

Specialty Product Revenues increased $47.5 million or 34.9%. Revenue increased in the workers' compensation insurance segment by $48.4 million, which was offset by a slight decrease in administrative services revenue of $900,000. The increase in the workers' compensation insurance segment was primarily due to a lower amount of ceded reinsurance premiums.

Workers' compensation net earned premiums are the end result of direct written premiums, plus the change in unearned premiums, less premiums ceded to reinsurers. Direct written premiums decreased by 7.9% due primarily to a 29% decrease in premium production that was partially offset by a 31% increase in composite premium rates. Ceded reinsurance premiums decreased by 82.7% due to the expiration of our low level reinsurance agreement on June 30, 2000 and a new reinsurance agreement with lower ceded premiums. Direct written premiums decreased from $203.3 million in 2000 to $187.1 million in 2001.

As compared to the low level reinsurance agreement that expired on June 30,

2000, the new reinsurance agreement results in higher net earned premium revenues, as we retain more of the premium dollars, but also leads to our keeping more of the incurred losses. This resulted in a higher loss and loss adjustment expense ratio, or LAE ratio, as the percentage increase in the additional incurred losses was greater than the percentage increase in the additional premiums retained. The effect on the balance sheet of the new reinsurance agreement compared to the low level agreements will eventually result in a lower amount of reinsurance recoverables, and due to the length of time over which claims expenses are typically paid, we expect to see an increase in future operating cash flow and amounts available to be invested.

Professional Fees decreased $4.2 million or 12.4% due primarily to the closing of our affiliated medical group in Arizona during 2000.

Investment and Other Revenues decreased $1.2 million or 5.4% due primarily to a decrease in the average investment yield during the period offset by an increase in the average invested balance.

Medical Expenses increased $32.0 million or 5.6%. Excluding the effects of changes in estimate charges for 2000, medical expenses increased approximately $58.0 million or 10.5%. Medical expenses as a percentage of medical premiums and professional fees decreased from 82.1% to 81.4%, excluding changes in estimate charges as described below. The improvement is primarily due to the closing of our rural Nevada clinical operation with a higher medical care ratio and premium yields in excess of cost increases.

Medical expenses reported in the first quarter of 2000 included $1.0 million of prior period reserve strengthening. In the second quarter of 2000, we recorded changes in estimate charges of $15.5 million for reserve strengthening primarily due to adverse development on prior years' medical claims and $9.5 million of other non-recurring medical costs primarily relating to the write-down of certain medical subsidiary assets.

Military Contract Expenses increased $8.4 million or 2.6%. The increase is consistent with the increase in revenues discussed previously. Health care delivery expense consists primarily of costs to provide managed health care services to eligible beneficiaries in accordance with Sierra's TRICARE contract. Under the contract, SMHS provides health care services to approximately 639,000 dependents of active duty military personnel and military retirees under the age of 65 and their dependents through a network of nearly 50,000 health care providers and certain other subcontractor partnerships. Also included in military contract expenses are costs incurred to perform specific administrative services, such as health care appointment scheduling, enrollment, network management and health care advice line services, and other administrative functions of the military health care subsidiary. These administrative services are performed for active duty personnel and family members as well as retired military families.

Specialty Product Expenses increased $35.8 million or 23.5%. Expenses increased in the workers' compensation operations by approximately $38.3 million as a direct result of the costs associated with the increase in workers' compensation premiums and associated loss and loss adjustment expenses. This increase was offset by a decrease in administrative services expense of $2.5 million.

The increase in the workers' compensation insurance segment expenses is primarily due to the following:

- Approximately $32.9 million in additional loss and LAE related to the increase in net earned premiums in 2001 compared to 2000.

- In 2001, we recorded $8.7 million of net adverse loss development for prior accident years compared to net adverse loss development of $23.3

million recorded in 2000. The net adverse development recorded was largely attributable to higher costs per claim, or claim severity, in California. Higher claim severity has had a negative impact on the entire California workers' compensation industry.

- We established a higher loss and LAE ratio for the 2001 accident year, which has resulted in an increase of approximately $12.5 million. The majority of the increase is due to the termination of the low level reinsurance agreement on June 30, 2000, which results in a higher risk exposure on policies effective after that date and a higher amount of net incurred loss and LAE.

- A net increase in underwriting expenses, policyholders' dividends and other operating expenses of $7.5 million related primarily to the increase in net earned premiums.

The net adverse loss development on prior accident years included those years that were covered by our low level reinsurance agreement. This results in an increase in the reinsurance recoverable balance which is then reduced by amounts collected from reinsurers. Net reinsurance recoverable decreased by $29.1 million in 2001 while they increased by $115.3 million in 2000.

The higher loss ratio we recorded for the 2001 accident year is in light of the lower premium rates on policies in prior years, inflationary trends in health care costs, the fact that we have seen our reserves develop adversely for the past three years and that projecting ultimate reserves cannot be done with 100% accuracy. We believed it prudent to establish reserves at a higher loss ratio to mitigate any future adverse loss development that may occur.

In February 2002, California enacted Assembly Bill 749. This new legislation will increase benefits paid to injured workers starting January 1, 2003. The Workers' Compensation Insurance Rating Organization of California, or WCIRB, has preliminarily estimated that the new legislation will increase the loss costs for accident year 2003 by approximately 7%. Increased loss costs, such as benefit increases, are normally built into the rating-making process so that premiums are increased to cover the increase in costs. Although we intend to increase our premiums, there is no assurance that our increase will be sufficient or that the WCIRB's estimate is accurate.

The loss and LAE reserves recorded as of December 31, 2001 reflect our best estimate of the ultimate loss costs for reported and unreported claims occurring in accident year 2001 as well as those occurring in accident years prior to 2001 and is slightly in excess of our independent actuary's estimate. Workers' compensation claim payments are made over several years from the date of the claim. Until the final payments for reported claims are made, reserves are invested to generate investment income.

Under our low level reinsurance agreement, we reinsured 30% of the first $10,000 of each claim, 75% of the next $40,000 and 100% of the next $450,000. The maximum net loss retained on any one claim ceded under this agreement was $17,000. This agreement covered all policies in force at July 1, 1998 and continued until June 30, 2000, when we exercised an option to extend coverage to all policies in force as of June 30, 2000. The termination of the low level agreement will result in our keeping more retained losses and LAE. However, our California premium rates have been increasing, which we believe will largely mitigate the loss of this favorable reinsurance protection. The premium rate increases on policies renewed in California during 2001 were approximately 38%. For policies effective from July 1, 2000, we obtained excess of loss reinsurance for 100% of the losses above $250,000 and less than $500,000. This agreement terminated on June 30, 2001 and only covered claims with dates of injury occurring by that date. We already had an existing excess of loss reinsurance agreement that covered 100% of the losses above $500,000. The latter reinsurance

agreement is a fixed rate multi-year contract that will expire December 31, 2002. We intend to execute an option to extend the coverage for all policies in force as of December 31, 2002 until they expire.

In the wake of the events of September 11, 2001 and the ensuing hardening of the reinsurance market, we expect our future reinsurance costs to increase and our coverage limits to decrease. We cannot currently estimate what the impact to our operating results will be when we obtain replacement coverage in January 2003. However, any increases in our reinsurance costs, including our retaining more of the risk, will most likely be factored into our premium rates.

Reinsurance contracts do not relieve us from our obligations to enrollees or policyholders. At December 31, 2001, we had over $220.1 million in reinsurance recoverable. We evaluate the financial condition of our reinsurers to minimize our exposure to significant losses from reinsurer insolvencies. At December 31, 2001, all of our reinsurers were rated AA and A+ or better by Fitch Ratings and the A.M. Best Company, respectively. Should these companies be unable to perform their obligations to reimburse us for ceded losses, we would experience significant losses.

The combined ratio is a measurement of the workers' compensation underwriting profit or loss and is the sum of the loss and LAE ratio, underwriting expense ratio and policyholders' dividend ratio. A combined ratio of less than 100% indicates an underwriting profit. Our combined ratio was 106.1% compared to 115.8% for 2000. The decrease was primarily due to significantly higher prior year adverse loss development recorded during 2000. Excluding adverse loss development, the combined ratio would have been 101.1% for 2001 and 97.3% for 2000. The increase in the accident year loss and LAE ratio was primarily due to the run off of the low level reinsurance, which is resulting in our retaining more of the incurred losses. The underwriting expense ratio decreased primarily due to higher retained net earned premiums.

General, Administrative and Marketing Expenses, or G&A, increased $12.4 million or 11.8%. As a percentage of revenues, G&A expenses were 9.1% for both periods. As a percentage of medical premium revenue, G&A expenses were 16.4% for 2001 compared to 16.5% for 2000.

Asset Impairment, Restructuring, Reorganization and Other Costs. We did not record any asset impairment, restructuring, reorganization and other costs in 2001. For a discussion of the costs recorded in 2000 and 1999 see the asset impairment, restructuring, reorganization and other costs section for the year ended December 31, 2000 compared to December 31, 1999.

Interest Expense and Other, Net decreased $799,000 or 4.1%. Interest expense related to the revolving credit facility decreased $13.3 million due to a decrease in the average balance of outstanding debt during the period offset by an increase in the weighted average cost of borrowing. Our average revolving credit facility balance was $61 million in 2001 compared to $183 million in 2000. Our average interest rate on the revolving credit facility, including the amortization of deferred financing fees and our interest rate swap agreement, was 10.6% in 2001 compared to 9.9% in 2000. Our average interest rate on the revolving credit facility, excluding the amortization of deferred financing fees and our interest rate swap agreement was 8.1% in 2001 compared to 9.8% in 2000. CII debenture interest decreased by $2.4 million in 2001, primarily as a result of the restructuring of the debentures. The decreases were offset by an increase in interest expense of $9.2 million related to the net financing obligations associated with the sale-leaseback transaction that was completed in December 2000. In 2001, we recorded a loss of $2.4 million on the sale of our Arizona properties compared to a net gain on sale of various assets of $1.1 million in 2000.

Provision for Income Taxes was recorded at $8.8 million for 2001 compared to a

tax benefit of $12.9 million for 2000. The effective tax rate for 2001 was 33.5% compared to 24.9% for 2000. The effective tax rate for 2000 reflects the non-deductibility of certain portions of goodwill impairment expense recorded during the period. Excluding the effect of the goodwill impairment expense, the effective tax rate for both periods was approximately 33.5%. Our ongoing effective tax rate is less than the statutory rate due primarily to tax preferred investments.

Discontinued Operations consist entirely of our Texas HMO health care operations. See Note 10 of the Notes to the Consolidated Financial Statements. We elected to early adopt Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets", or SFAS No. 144, effective January 1, 2001. In the third quarter of 2001, we decided to exit the Texas HMO health care market and received approval from the Texas Department of Insurance in mid-October 2001. We will cease providing HMO health care coverage on April 17, 2002. In accordance with SFAS No. 144, our Texas HMO health care operations are now reclassified as a discontinued operation. The net loss from discontinued operations was $14.0 million in 2001 compared to $161.1 million in 2000. Included in the 2001 loss are estimated costs to exit the Texas HMO health care market of $17.1 million. Included in the 2000 loss were the following: (a) asset impairment charges of $126.4 million for impaired goodwill; (b) $36.5 million for impaired real estate and other fixed assets; (c) medical expenses of $14.7 million, primarily for adverse development on prior periods' medical claims; (d) $15.5 million for premium deficiency medical costs; (e) $10.4 million for premium deficiency maintenance costs; and (f) other restructuring, reorganization and other costs of $13.3 million. The utilization of prior premium deficiency reserves were $23.3 million in 2001 and $32.4 million in 2000.

Year Ended December 31, 2000 Compared to 1999

Total Operating Revenues for 2000 increased approximately 11.6% to $1.16 billion from $1.04 billion for 1999. Medical premium revenues accounted for approximately 55.0% and 57.3% of our total revenues for the years ended December 31, 2000 and 1999, respectively. The decrease in medical premiums as a percentage of total revenues in 2000 is primarily due to the increase in specialty product and military contract revenues.

The change in operating revenues was comprised of the following:

- An increase in medical premiums of $42.8 million
- An increase in military contract revenues of $43.0 million
- An increase in specialty product revenues of $41.6 million
- A decrease in professional fees of $9.0 million
- An increase in investment and other revenues of $2.1 million

Medical Premiums from our HMO and managed indemnity insurance subsidiaries increased $42.8 million or 7.2%. The $42.8 million increase in premium revenue reflects a 1.2% increase in Medicare member months (the number of months individuals are enrolled in a plan) offset by a 1.2% decrease in commercial member months. The growth in Medicare member months contributes significantly to the increase in premium revenues as the Medicare per member premium rates are over three times higher than the average commercial premium rate. HMO premium rates for commercial groups increased approximately 4% in Nevada. Our managed indemnity rates increased approximately 12% and Medicare rates increased

approximately 2%.

Military Contract Revenues increased $43.0 million or 14.9%. The increase was primarily attributable to additional accrued bid price adjustment revenues related to a true-up of prior periods' information received from the government in the third quarter of 2000. Partially offsetting this was a decrease recorded in the first quarter for a reduction in the at-risk health care population of beneficiaries as additional beneficiaries enrolled with military treatment facility primary care managers. We are not at-risk for those TRICARE eligibles and receive less revenue related to them from the government.

Specialty Product Revenues increased $41.6 million or 44.2%. Revenue increased in the workers' compensation insurance segment by $42.7 million, which was offset by a slight decrease in administrative services revenue of $1.1 million. The increase in the workers' compensation insurance segment was primarily due to a larger amount of direct written premiums with an 18% composite increase in premium rates for all states and a 24% increase in production growth.

Net earned premiums are the end result of direct written premiums, plus the change in unearned premiums, less premiums ceded to reinsurers. Direct written premiums increased by 37% due primarily to growth in California and Nevada. Partially offsetting the growth in direct written premiums was an increase in premiums ceded to reinsurers, which increased by 22%. The growth in ceded reinsurance premiums was lower than the growth in direct written premiums primarily due to the expiration of our low level reinsurance agreement on June 30, 2000 and new lower cost reinsurance agreements, all of which reduced the percentage of premiums being ceded. Direct written premiums increased from $148.8 million in 1999 to $203.3 million in 2000.

As compared to the low level reinsurance agreement that expired on June 30, 2000, the new lower cost reinsurance agreements result in higher net earned premium revenues, as we retain more of the premium dollars, but also leads to our keeping more of the incurred losses. This may result in a higher loss and loss adjustment expense, or LAE, ratio if the percentage increase in the additional incurred losses should be greater than the percentage increase in the additional premiums we retained. The effect on the balance sheet will result in a lower amount of reinsurance recoverables. However, due to the length of time that it typically takes to fully pay a claim, we should see an increase in operating cash flow and amounts available to be invested.

Professional Fees decreased $9.0 million or 21.3%. The revenue for 1999 included the inpatient operations at the Mohave Valley Hospital until they were closed during the first quarter of 1999. The fees in 2000 also reflect staffing reductions and subsequent closure of our affiliated medical group in Arizona.

Investment and Other Revenues increased $2.1 million or 10.3% due primarily to an increase in the average invested balance during the year.

Medical Expenses increased $42.1 million or 7.9%. Excluding the effects of changes in estimate charges, medical expenses increased approximately $38.2 million or 7.5%. Medical expenses as a percentage of medical premiums and professional fees increased from 80.5% to 82.1%, excluding changes in estimate charges and premium deficiency as described below. The increase is primarily due to an increase in Medicare members as a percentage of fully-insured members. The cost of providing medical care to Medicare members generally requires a greater percentage of the premiums received.

Medical expenses reported in the first quarter of 2000 included $1.0 million of prior period reserve strengthening. In the second quarter of 2000, we recorded changes in estimate charges of $15.5 million for reserve strengthening primarily due to adverse development on prior years' medical claims and $9.5 million of other non-recurring medical costs primarily related to the write-down of medical

subsidiary assets.

During 1999, we reported a premium deficiency medical charge of $8.1 million related to losses in under-performing markets primarily in Arizona and rural Nevada, all of which was used during 1999. Also recorded in medical expenses during the fourth quarter was $7.2 million primarily related to an adjustment to the estimate for medical expenses recorded in previous years, and $6.8 million primarily related to contractual settlements with providers of medical services.

Military Contract Expenses increased $46.8 million or 16.9%. The increase is consistent with the increase in revenues discussed previously. Also, included in military contract expenses are costs incurred to perform specific administrative services, such as health care appointment scheduling, enrollment, network management and health care advice line services, and other administrative functions of the military health care subsidiary.

Specialty Product Expenses increased $56.2 million or 58.3%. Of the increase, approximately $32.1 million is a direct result of the costs associated with the increase in workers' compensation premiums and associated loss and loss adjustment expenses.

We recorded net adverse loss development for prior accident years of $23.3 million in 2000 compared to $9.9 million in 1999. The net adverse development recorded in 1999 and 2000 for prior accident years was largely attributable to higher costs per claim, or claim severity, in California. Higher claim severity has had a negative impact on the entire California workers' compensation industry. The majority of the adverse loss development occurred on accident years that were not covered by our low level reinsurance agreement. While the low level reinsurance agreement was in run-off effective July 1, 2000, California premium rates have been increasing, which we believe will largely mitigate the loss of this very favorable reinsurance protection. The premium rate increases on policies renewed in California during the year ended December 31, 2000 were approximately 26% and for the second half of the year alone, averaged approximately 36%.

We recorded a higher loss and LAE ratio for the 2000 accident year, which resulted in an increase of approximately $8.6 million in specialty product expense. The majority of the increase is due to the termination of the low level reinsurance agreement on June 30, 2000, which results in a higher risk exposure on policies effective after that date and a higher amount of net incurred loss and LAE. In addition, in light of the lower premium rates on policies written in 1999, inflationary trends in health care costs, the fact that we have seen our reserves develop adversely for the past two years and that projecting ultimate reserves cannot be done with 100% accuracy, we believed it prudent to establish reserves at a higher loss ratio to mitigate any future adverse loss development that may occur.

The loss and LAE reserves recorded as of December 31, 2000 reflect our best estimate of the ultimate loss costs for reported and unreported claims occurring in accident year 2000 as well as those occurring in accident years prior to 2000 and was slightly in excess of our independent actuary's estimate. Workers' compensation claim payments are made over several years from the date of the claim. Until the final payments for reported claims are made, reserves are invested to generate investment income.

Under our low level reinsurance agreement, we reinsured 30% of the first $10,000 of each claim, 75% of the next $40,000 and 100% of the next $450,000. The maximum net loss retained on any one claim ceded under this agreement was $17,000. This agreement covered all policies in force at July 1, 1998 and continued until June 30, 2000 when we exercised an option to extend coverage to all policies in force as of June 30, 2000. For policies effective from July 1, 2000, we obtained excess of loss reinsurance for 100% of the losses above

$250,000 and less than $500,000. We already had an existing excess of loss reinsurance agreement that covered 100% of the losses above $500,000. (See Note 6 of Notes to the Consolidated Financial Statements).

The combined ratio is a measurement of the workers' compensation underwriting profit or loss and is the sum of the loss and LAE ratio, underwriting expense ratio and policyholders' dividend ratio. A combined ratio of less than 100% indicates an underwriting profit. Our combined ratio was 115.8% compared to 105.5% for 1999. The increase was primarily due to a higher loss and LAE ratio of 13.4 percentage points and policyholders' dividend ratio of 1.6 percentage points, offset slightly by a decrease in the underwriting expense ratio of 4.7 percentage points. The increase in the loss and LAE ratio was due to an increase in net adverse loss development, which represents 6.6 percentage points of the change in the loss and LAE ratio, and a higher loss and LAE ratio on the 2000 accident year of $8.6 million, which represents 6.8 percentage points of the change in the loss and LAE ratio.

General, Administrative and Marketing Expenses, or G&A, increased $10.9 million or 11.5%. As a percentage of revenues, G&A costs were 9.1% for both periods. As a percentage of medical premium revenue, G&A costs increased from 15.9% for 1999 to 16.5% for 2000.

Asset Impairment, Restructuring, Reorganization and Other Costs for 1999 and 2000 are discussed below.

Asset Impairments. During the first quarter of 1999, we closed all inpatient operations at Mohave Valley Hospital, a 12-bed acute care facility in Bullhead City, Arizona, and terminated over 40 employees. We recorded a charge of $3.5 million for the write-off of goodwill associated with these operations.

Management adopted a plan in the second quarter of 2000 to discontinue medical delivery operations in Mohave County, Arizona and to sell the real estate assets located there, as well as an underperforming medical clinic in Las Vegas. In connection with the restructuring plans adopted and announced by us in the second quarter of 2000, we re-evaluated the recoverability of certain long-live assets, in accordance with Statement of Financial Accounting Standards No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of", or SFAS No. 121, and Accounting Principles Board Opinion No. 17, "Intangible Assets", or APB No. 17, and determined that the carrying values of certain goodwill and other long-lived assets were impaired.

In assessing the asset impairment of the long-lived assets, we first allocated a portion of related goodwill to the fixed assets to be disposed of, in accordance with SFAS No. 121. The fixed assets were then written down to estimated fair value less costs to sell, which was determined from independent valuations. The remainder of the related goodwill was then assessed for recoverability in accordance with APB No. 17 based on projected discounted cash flows.

The charges recorded for the write-off of goodwill totaled $15.1 million related primarily to the Prime Holdings, Inc. acquisition. The charges recorded for fixed asset impairment totaled $9.5 million for the Arizona and Nevada operations.

During the second quarter of 2000, we wrote-off capitalized costs of $3.0 million related to the application development of an information system software project for the workers' compensation operations, which was canceled because the vendor was unable to fulfill its contractual obligations. The amounts written off included software and consulting costs of $1.6 million and capitalized internal personnel costs of $1.4 million.

Restructuring and Reorganization. In the first quarter of 1999, we incurred $450,000 for certain legal and contractual settlements and $400,000 to provide

for our portion of the write-off of start-up costs at our equity investee, TriWest Healthcare Alliance.

In the second quarter of 2000, we adopted a plan and announced additional restructuring of the Arizona managed health care operations. As a result of this restructuring, we recorded charges in accordance with Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (Including Certain Costs Incurred in a Restructuring)" of approximately $2.0 million. Of the costs recorded, $1.2 million was for severance, $400,000 was related to clinic closures and lease termination and $400,000 was for other costs.

Other:

The $3.4 million of charges in the fourth quarter of 1999 consisted primarily of legal and contractual settlements.

The $4.3 million of costs recorded in the second quarter of 2000 relate primarily to the write-down of certain receivables as well as an accrual for certain legal settlements.

The table below presents a summary of asset impairment, restructuring, reorganization and other costs for the years indicated.

(In thousands)	Asset Impairment	Restructuring and Reorganization
Balance, January 1, 1999		
Charges recorded	$ 3,509	$ 850
Cash used		(850)
Noncash activity	(3,509)	
Changes in estimate		
Balance, December 31, 1999	-	-
Charges recorded	27,553	1,983
Cash used		(1,389)
Noncash activity	(27,553)	
Changes in estimate		
Balance, December 31, 2000	-	594
Charges recorded		
Cash used		(594)
Noncash activity		
Changes in estimate		
Balance, December 31, 2001	$ -	$ -

The remaining other costs of $4.4 million are primarily related to legal claims. Management believes that the remaining reserves as of December 31, 2001 are adequate and that no revisions to the estimates are necessary at this time.

Interest Expense and Other, Net increased $2.9 million or 17.3% due primarily to an increase in the average balance of outstanding debt and an increase in the

average cost of borrowing. Our average credit facility debt balance was $183 million in 2000 compared to $164 million in 1999 and our average interest rate on the credit facility was 9.9% in 2000 compared to 7.8% in 1999.

Benefit for Income Taxes was $12.9 million for 2000 compared to tax expense of $2.2 million for 1999. The effective tax rate for 2000 was 24.9% compared to 17.3% for 1999. The effective tax rates for 2000 and 1999 reflect the non-deductibility of certain portions of goodwill impairment expense recorded during the periods. In addition, during 1999, due to a change in tax law, we were able to utilize a $1.6 million net operating loss carryover that had previously not been recognized in the financial statements due to uncertainty about its realization. Excluding the effect of the items described above, the effective tax rate for both periods was approximately 33.5%. Our ongoing effective tax rate is less than the statutory rate due to tax preferred investments offset by state income taxes.

Discontinued Operations consist entirely of our Texas HMO health care operations as previously discussed and described in Note 10 of the Notes to Consolidated Financial Statements. The net loss from discontinued operations was $161.1 million in 2000 compared to $15.2 million in 1999. Included in the 2000 loss were the following: (a) asset impairment charges of $126.4 million for impaired goodwill; (b) $36.5 million for impaired real estate and other fixed assets; (c) medical expenses of $14.7 million, primarily for adverse development on prior periods' medical claims; (d) $15.5 million for premium deficiency medical costs; (e) $10.4 million for premium deficiency maintenance costs; and (f) other restructuring, reorganization and other costs of $13.3 million. Included in the 1999 loss was a premium deficiency medical charge of $14.0 million and $11.0 million in premium deficiency maintenance costs. The utilization of prior premium deficiency reserves were $32.4 million in 2000 and $18.2 million in 1999.

LIQUIDITY AND CAPITAL RESOURCES

We had cash flows from operating activities for continuing operations of $124.5 million for the year ended December 31, 2001 compared to $25.2 million in 2000. We used the majority of the cash flows to make cash payments for debt reductions of $81.0 million. Overall, discontinued operations used cash of $34.0 million in 2001 compared to providing cash of $11.6 million in 2000. The improvement in continuing operations over 2000 is primarily attributable to cash from earnings and the change in assets and liabilities.

The cash flow resulting from the change in assets and liabilities of $77.5 million was primarily due to the following:

- a source of cash due to the decrease in reinsurance recoverable of $31.6 million primarily from our workers' compensation business
- a source of cash due to the increase in the reserve for losses and loss adjustment expense of $11.2 million
- a source of cash due to the decrease in the military accounts receivable balance of $32.4 million
- a source of cash due to the increase in medical claims payable of $7.3 million
- a use of cash due to the decrease in military health care payable of $7.6 million
- various other changes in assets and liabilities accounting for the remaining source of cash of $2.6 million

SMHS receives monthly cash payments equivalent to one-twelfth of its annual contractual price with the Department of Defense, or DoD. SMHS accrues health care revenue on a monthly basis for any monies owed above its monthly cash receipt based on the number of at-risk eligible beneficiaries and the level of military direct care system utilization. The contractual bid price adjustment, or BPA, process serves to adjust the DoD's monthly payments to SMHS, because the payments are based in part on 1996 DoD estimates for beneficiary population and beneficiary population baseline health care cost, inflation and military direct care system utilization. As actual information becomes available for the above items, quarterly adjustments are made to SMHS' monthly health care payment in addition to lump sum adjustments for past months. In addition, SMHS accrues change order revenue for DoD directed contract changes. During the second, third, and fourth quarters of 2001, SMHS received $22.2 million, $9.9 million and $4.6 million, respectively, as partial payments from the BPA process covering the period June 1, 1999 through August 31, 2001. As a result of preliminary data accumulated from the BPA process, SMHS received a partial upward adjustment of approximately $4.1 million to its monthly DoD payments for January 2001 through December 2001. Our business and cash flows could be adversely affected if the timing or amount of the BPA and change order reimbursements vary significantly from our expectations.

On November 16, 2001, SMHS entered into a securitization arrangement with General Electric Capital Corporation. The arrangement provides for the sale of SMHS' Federal Government accounts receivable to SMHS Funding, LLC. SMHS Funding is a special purpose limited liability company owned by SMHS and was formed for the purpose of purchasing all receivables of SMHS. This entity is fully consolidated into SMHS. SMHS Funding, LLC may sell an undivided interest in certain of the receivables to a subsidiary of General Electric Capital Corporation in the event that additional financing by SMHS is warranted. This securitization arrangement was not utilized in 2001 and we do not anticipate utilizing it in 2002. (See Note 1 of Notes to the Consolidated Financial Statements).

Net cash used from continuing operations for investing activities during 2001 included $9.5 million in capital expenditures associated with continued implementation of new computer systems, as well as facilities, furniture, equipment and other capital needs to support our growth, offset by net proceeds of $7.3 million for property and equipment dispositions. The net cash change in investments for the year was an increase of $51.1 million as investments were purchased with available funds.

Cash used in financing activities during 2001 included payments of $81.0 million on debt related items offset by $2.1 million in cash received related to the sale of stock through our employee stock purchase plan. The year 2000 included net proceeds from long-term borrowings (proceeds less payments) of $48.8 million and proceeds of $1.6 million related to the sale of stock through our employee stock purchase plan.

On December 28, 2000, we sold the majority of our Las Vegas real estate holdings in a sale-leaseback transaction. The transaction was recorded as a financing obligation of $113.7 million offset by mortgage notes receivable of $22.2 million and a payoff of related real estate mortgages of $9.9 million. From the proceeds, we made a permanent reduction on our revolving credit facility of $50 million for a net increase in liabilities of $31.6 million. During 2001, we received full payment on the outstanding mortgage notes receivable associated with three of the medical clinics. This allowed these clinics to qualify as a sale. The impact of the sale of the three clinics was a net reduction of $13.4 million in property and equipment, a $14.6 million net reduction in the associated financing obligation and a deferred gain of $6.1 million. The deferred gain will be recognized over the remaining 14 years of the lease term. (See Note 4 of Notes to the Consolidated Financial Statements).

Revolving Credit Facility

Our revolving credit facility balance decreased from $135 million to $89 million during the year. As a result of the asset impairment and other changes in estimate charges, we were not in compliance with our financial covenants at June 30, 2000. On December 15, 2000, we entered into an amended and restated credit agreement, which terminates on September 30, 2003, and are now in compliance with all covenants of the amended agreement. The restated agreement was amended in April 2001 to allow for the completion of the CII debenture exchange offer and again in October 2001 to provide a limited waiver for covenants affected by exiting the Texas HMO health care market. The availability under the credit facility has been reduced to $117 million at December 31, 2001 from $135 million at the end of 2000 due to reductions required in the agreement. At December 31, 2001, we had $28 million available under the credit facility, however the total availability will be reduced by $6.0 million on June 30, 2002 and December 31, 2002 and finally by $10.0 million on June 30, 2003.

Interest under the amended and restated credit agreement is variable and based on the Bank of America "prime rate" adjusted for a margin. The rate was 5.375% at December 31, 2001, which is a combination of the prime rate of 4.75% plus a margin of .625%. The margin will be reduced by 1.0% at the end of the first quarter of 2002 since we exceeded certain ratio requirements as of December 31, 2001. We can further reduce the margin in the future by completing certain transactions and meeting certain financial ratios. Of the outstanding balance, $25 million is covered by an interest-rate swap agreement. To mitigate the risk of interest rate fluctuation on the credit facility, we entered into a five-year $50 million interest-rate swap agreement during the fourth quarter of 1998. The intent of the agreement was to keep our interest rate on $50 million of the borrowing relatively fixed. In the fourth quarter of 2000, $25 million of the swap agreement was terminated. In accordance with Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" we recorded the interest-rate swap agreement to fair market value as of December 31, 2001. The fair market value indicated that we would need to pay $685,000 to terminate the swap agreement.

The average cost of borrowing on the credit facility for 2001, including the amortization of deferred financing fees and the impact of the swap agreement, was 10.6%. The terms of the amended and restated credit agreement contain certain covenants including a minimum fixed charge coverage ratio, a minimum interest coverage ratio, a maximum leverage ratio, maximum loss ratios and maximum capital expenditure amounts. We believe that we are in compliance with these covenants at December 31, 2001.

Going forward, under certain circumstances, we will be required to make prepayments on the credit facility and the amount available to us under the credit facility will be further reduced. For example, 80% of any excess cash flow that we have in each year must be applied to a repayment of the credit facility. In addition, if we or one of our subsidiaries (other than a regulated subsidiary and other specified subsidiaries) engage in an asset sale or a sale-leaseback transaction (with the exception of assets specified in the amended credit agreement), 80% of the net cash proceeds must be applied to a repayment of the credit facility and a reduction of the amount available under the credit facility. In addition, 100% of the net cash proceeds of a debt issuance (excluding issuances by CII Financial, a wholly-owned subsidiary) must be applied to a repayment of the credit facility and a reduction in the amount available under the credit facility.

We are also limited in the amount of funds we can invest in our Texas and Military operations. The maximum we can invest in the Military operations is $5 million. We have not invested any of the $5 million as of December 31, 2001. After September 30, 2001, we can invest an additional $5.0 million in the Texas operations and replace the Texas real estate assets with cash and notes up to

$46 million. Under the terms of the amended and restated agreement, the use of Sierra funds to pay the outstanding Texas mortgage note of $29.2 million is not considered an investment in the Texas operations. During the fourth quarter of 2001, we invested in Texas the full $5.0 million allowed under the amended and restated agreement. If we had to invest more than we are allowed, we would be required to get a waiver or an amendment to our agreement or be out of compliance. If additional funds are needed by our discontinued Texas HMO health care operations and we do not transfer such funds they may be in violation of certain insurance regulations and we may be required to get a waiver or an amendment to our agreement or be out of compliance. There is no assurance that if we needed a bank waiver or amendment that we would be able to obtain it. Based on the current estimated Texas HMO healthcare run-out costs and recorded reserves, we believe we have adequate funds available and the ability to invest adequate funds in Texas to meet the anticipated obligations.

Subject to normal qualifications and exceptions, Sierra and CII Financial have covenants that, among other things, restrict our ability to dispose of assets, incur indebtedness, pay dividends, make investments, loans or advances, make acquisitions, engage in mergers or consolidations, or make capital expenditures and which otherwise restrict certain corporate activities. At January 31, 2002, our credit facility had outstanding borrowings of $81 million. Unused credit facility balances are primarily reserved for our working capital purposes. Any availability under the credit facility generated from our excess cash flow must be converted annually to permanent reductions in accordance with the terms of the credit facility.

Debentures

At September 30, 2000, CII Financial, Inc. had approximately $47.1 million of subordinated debentures that were due on September 15, 2001. These subordinated debentures were neither assumed nor guaranteed by Sierra and were subordinated to Sierra's credit facility debt. In December 2000, CII Financial commenced an offer to exchange the subordinated debentures for cash and/or new debentures. On May 7, 2001, CII Financial closed its exchange offer on $42.1 million of its outstanding subordinated debentures. CII Financial purchased $27.1 million in principal amount of subordinated debentures for $20.0 million in cash and issued $15.0 million in new 9 1/2% senior debentures, due September 15, 2004, in exchange for $15.0 million in subordinated debentures. The transaction was accounted for as a restructuring of debt; therefore all future cash payments, including interest, related to the debentures will be reductions of the carrying amount of the debentures and no future interest expense will be recognized. Accordingly, the new 9 1/2% senior debentures have a carrying amount of $19.2 million consisting of principal of $15.0 million and $4.2 million in future accrued interest.

In September 2001, the California Department of Insurance gave approval to California Indemnity, one of CII Financial's insurance subsidiaries, to pay a dividend of $5.0 million to CII Financial. CII Financial used these funds to pay the remaining $5.0 million in subordinated debentures at maturity.

The new 9 1/2% senior debentures pay interest, which is due semi-annually on March 15 and September 15 of each year, commencing on September 15, 2001. The new 9 1/2% senior debentures rank senior to outstanding notes payable from CII Financial to Sierra and CII Financial's guarantee of Sierra's revolving credit facility. The new 9 1/2% senior debentures may be redeemed by CII Financial at any time at premiums starting at 110% and declining to 100% for redemptions after April 1, 2004. In the event of a change in control of CII Financial, the holders of the new 9 1/2% senior debentures may require that CII Financial repurchase them at the then applicable redemption price, plus accrued and unpaid interest.

CII is a holding company and its only significant asset is its' investment in

California Indemnity. Of the $8.6 million in cash and cash equivalents it held at December 31, 2001, approximately $8.1 million was designated for use only by the regulated insurance companies. CII has limited sources of cash and is dependent upon dividends paid by California Indemnity. California Indemnity may only pay a dividend without the prior approval of the state insurance commissioner to the extent the cumulative amount of dividends or distributions paid or proposed to be paid in any year does not exceed the amount shown as unassigned funds (reduced by any unrealized gains or losses included in any such amount) on its statutory statement as of the previous December 31. In 2002, California Indemnity can pay dividends of up to $2.1 million without the prior approval of the state insurance commissioner. In 2001, California Indemnity received prior approval to pay an aggregate of $10 million in dividends. We are not in a position to assess the likelihood of obtaining future approval for the payment of dividends other than those specifically allowed by law in each of our subsidiaries' state of domicile.

Statutory Capital and Deposit Requirements

Our HMO and insurance subsidiaries are required by state regulatory agencies to maintain certain deposits and must also meet certain net worth and reserve requirements. The HMO and insurance subsidiaries had restricted assets on deposit in various states totaling $26.0 million at December 31, 2001. The HMO and insurance subsidiaries must also meet requirements to maintain minimum stockholders' equity, on a statutory basis, as well as minimum risk-based capital requirements, which are determined annually. Additionally, in conjunction with the Kaiser-Texas acquisition, TXHC entered into a letter agreement with the Texas Department of Insurance whereby TXHC agreed to maintain a net worth of $20.0 million, on a statutory basis, until certain income levels were achieved. In conjunction with the exit from the Texas HMO health care market, the Texas Department of Insurance approved a plan of withdrawal and TXHC is now required to maintain deposits and net worth of at least $3.5 million. We believe we are in compliance with our regulatory requirements. We are limited by our credit facility in the amount of funds we can invest in our Texas operations as previously discussed.

Of the $115.8 million in cash and cash equivalents held at December 31, 2001, $84.1 million was designated for use only by the regulated subsidiaries. Amounts are available for transfer to the holding company from the HMO and insurance subsidiaries only to the extent that they can be remitted in accordance with the terms of existing management agreements and by dividends. The holding company will not receive dividends from its regulated subsidiaries if such dividend payment would cause violation of statutory net worth and reserve requirements.

Obligations and Commitments

The following schedule represents our obligations and commitments for long-term debt, capital leases and operating leases. With the exception of our revolving credit facility, the amounts below represent the entire payment, principal and interest, on our outstanding obligations. Based on the outstanding balance of the revolving credit facility of $89 million as of December 31, 2001, we are not required to make any principal payments until the balance is due in 2003.

	Long-Term Debt	Capital Leases	Operatin Leases
(In thousands)			
Continuing Operations			
Payments due in less than 1 year.....	$ 11,781	$115	$ 8,805
Payments due in 1 to 3 years.....	127,841	204	12,685
Payments due in 4 to 5 years.....	21,646	61	9,899
Payments due after 5 years.....	105,996	184	26,965
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Total Continuing Operations.....	$ 267,264	$564	$58,354
Discontinued Operations			
Payments due in less than 1 year.....		$188	
Payments due in 1 to 3 years.....	$ 5,065	47	
Payments due in 4 to 5 years.....	24,124		
Payments due after 5 years.....			
Total Discontinued Operations.....	$ 29,189	$235	

Included in long-term debt payments for continuing operations is $158.2 million for our net financing obligation related to the sale-leaseback transaction. We expect the transaction will qualify as a sale by the end of 2002 at which time the future payments due will be categorized as operating leases. In conjunction with the remainder of the transaction qualifying as a sale, we will receive proceeds of $21.2 million, primarily from notes receivable due to us. See Note 4 and Note 8 of Notes to the Consolidated Financial Statements for a more detailed discussion of the sale-leaseback transaction.

The amount included in long-term debt payments for discontinued operations is for a mortgage loan secured by certain underlying real estate assets of the discontinued operations. We are actively seeking a buyer for the assets and anticipate selling them by the end of 2002. As the assets are sold, we are required to make reductions on the mortgage note and completely satisfy the obligation once all of the assets have been sold.

Other

We have a 2002 capital budget of $16.1 million and we are limited to $19.6 million by our revolving credit facility. The planned expenditures are primarily for the purchase of computer hardware and software, furniture and equipment and other normal capital requirements. Our liquidity needs over the next 12 months will primarily be for the capital items noted above, debt service and funds required to exit the Texas HMO health care market. We believe that our existing working capital, operating cash flow and, if necessary, equipment leasing, divestitures of certain non-core assets and amounts available under our credit facility should be sufficient to fund our capital expenditures and debt service. Additionally, subject to unanticipated cash requirements, we believe that our existing working capital and operating cash flow should enable us to meet our liquidity needs on a long-term basis.

We have a $25 million interest-rate swap agreement that allows us to mitigate the risk of interest rate fluctuation on our credit facility. The intent of the agreement was to keep our interest rate on $25 million of the credit facility relatively fixed. In accordance with Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" we recorded the interest-rate swap agreement to fair market value as of December 31, 2001. The fair market value indicated that we would need to pay $685,000 to terminate the swap agreement. If the prime rate were to decrease by 1%, we estimate our maximum increase in annual expense associated with the swap to be approximately $250,000.

In the second quarter of 1997, our Board of Directors authorized a $3.0 million loan from us to our Chief Executive Officer, or CEO. In April 2000, our Board of Directors authorized an additional $2.5 million loan from us to the CEO. The entire principal balance along with accrued interest is due on June 30, 2002. During 2001, the CEO made payments of $898,000 and at the end of 2001, the aggregate principal balance outstanding and accrued interest for both instruments was $5.0 million. All amounts borrowed bear interest at a rate equal to the rate at which we could have borrowed funds under our revolving credit

facility at the time of the borrowing plus 10 basis points. The amounts outstanding are collateralized by certain of the CEO's assets and rights to compensation from us.

Inflation

Health care costs continue to rise at a rate faster than the Consumer Price Index. We use various strategies to mitigate the negative effects of health care cost inflation, including setting commercial premiums based on our anticipated health care costs, risk-sharing arrangements with our various health care providers and other health care cost containment measures including member co-payments. There can be no assurance, however, that in the future, our ability to manage medical costs will not be negatively impacted by items such as technological advances, competitive pressures, applicable regulations, increases in pharmacy costs, utilization changes and catastrophic items, which could, in turn, result in medical cost increases equaling or exceeding premium increases.

Government Regulation

Our business, offering health care coverage, health care management services, workers' compensation programs and, to a lesser extent, the delivery of medical services, is heavily regulated at both the federal and state levels.

Government regulation of health care coverage products and services is a changing area of law that varies from jurisdiction to jurisdiction. Changes in applicable laws and regulations are continually being considered, including legislative proposals to eliminate or reduce ERISA pre-emption of state laws, that would increase potential litigation exposure and interpretation of existing laws and rules also may change from time to time. Regulatory agencies generally exercise broad discretion in promulgating regulations and in interpreting and enforcing laws and regulations.

While we are unable to predict what regulatory changes may occur or the impact on us of any particular change, our operations and financial results could be negatively affected by regulatory changes. For example, any proposals affecting underwriting practices, limiting rate increases, increasing litigation exposure, requiring new or additional benefits or affecting contracting arrangements (including proposals to require HMOs and PPOs to accept any health care providers willing to abide by an HMO's or PPO's contract terms) may have a material adverse effect on our business. The continued consideration and enactment of "anti-managed care" laws and regulations by federal and state bodies may make it more difficult for us to manage medical costs and may adversely affect financial results.

In addition to changes in applicable laws and regulations, we are subject to various audits, investigations and enforcement actions. These include possible government actions relating to ERISA, which regulates insured and self-insured health coverage plans offered by employers, the Federal Employees Health Benefit Plan, federal and state fraud and abuse laws, and laws relating to utilization management and the delivery of health care. Any such government action could result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including exclusion from participation in government programs. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services.

In addition to the items described above, we urge you to review carefully the section "Risk Factors" in this 2001 Form 10-K for a more complete discussion of the risks associated with an investment in our securities. See "Note on Forward-Looking Statements and Risk Factors" under Item 1.

Recently Issued Accounting Standards

In July 2001, the FASB issued Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets", or SFAS No. 142, which is effective January 1, 2002. SFAS No. 142 requires, among other things, the discontinuance of goodwill amortization. In addition, the pronouncement includes provisions for the reclassification of certain existing recognized intangibles as goodwill, reassessment of the useful lives of existing recognized intangibles, reclassification of certain intangibles out of previously reported goodwill and the identification of reporting units for purposes of assessing potential future impairments of goodwill. SFAS No. 142 also requires us to complete a transitional goodwill impairment test six months from the date of adoption. The net amortized goodwill balance at December 31, 2001 was $14.8 million and goodwill amortization during the year was $805,000 and would have been approximately the same amount in 2002 under current accounting standards. We have performed an evaluation of the impact of SFAS No. 142 on our operations and have determined that our recorded goodwill will not be impaired under the guidelines of the pronouncement.

In October 2001, the FASB issued Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets", or SFAS No. 144, which is effective for fiscal years beginning after December 15, 2001 with early adoption recommended. SFAS No. 144 requires that long-lived assets that are to be sold within one year must be separately identified and carried at the lower of carrying value or fair value less costs to sell. Long-lived assets expected to be held longer than one year are subject to depreciation and must be written down to fair value upon impairment. Long-lived assets no longer expected to be sold within one year, such as foreclosed real estate, must be written down to the lower of current fair value or fair value at the date of foreclosure adjusted to reflect depreciation since acquisition. As discussed in Note 4 of Notes to the Consolidated Financial Statements, we have elected to adopt SFAS No. 144 effective January 1, 2001.

ITEM 7a. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk for the impact of interest rate changes and changes in the market value of our investments. We have not utilized derivative financial instruments in our investment portfolio.

Our exposure to market risk for changes in interest rates relates primarily to our investment portfolio and our long-term debt. As of December 31, 2001, we have approximately $411.0 million in cash and cash equivalents and current, long-term and restricted investments. Of the investments, approximately $281.4 million is classified as available-for-sale and $13.8 million is classified as held-to-maturity. These investments are primarily in fixed income, investment grade securities. Our investment policy emphasizes return of principal and liquidity and is focused on fixed returns that limit volatility and risk of principal. Because of our investment policies, the primary market risk associated with our portfolio is interest rate risk.

Assuming interest rates were to increase by a factor of 1.1, the net hypothetical loss in fair value of stockholders' equity related to financial instruments is estimated to be approximately $4.9 million after tax (5.1% of total stockholders' equity). We believe that such an increase in interest rates would not have a material impact on future earnings or cash flows, as it is unlikely that we would need or choose to substantially liquidate our investment portfolio.

The effect of interest rate risk on potential near-term net income, cash flow and fair value was determined based on commonly used interest rate sensitivity

analyses. The models project the impact of interest rate changes on a wide range of factors, including duration and prepayment. Fair value was estimated based on the net present value of cash flows or duration estimates, assuming an immediate 10% increase in interest rates. Because duration is estimated, rather than a known quantity, for certain securities, other market factors may impact security valuations and there can be no assurance that our portfolio would perform in line with the estimated values.

As of December 31, 2001, we had $89 million in borrowings outstanding under a revolving credit facility. The average cost of borrowing on this credit facility for 2001, including the amortization of deferred financing fees and the impact of the interest-rate swap agreement, was 10.6%. If the average cost of borrowing on the amount outstanding as of December 31, 2001 were to increase by a factor of 1.1, our annual income before tax would decrease by approximately $900,000.

As of December 31, 2001, CII had $15.0 million in senior debentures outstanding. The debentures trade on the New York Stock Exchange. The fair market value of the outstanding debentures was estimated to be approximately $13.0 million at December 31, 2001, based on the last trade in 2001. If interest rates were to fluctuate by a factor of 1.1, we do not anticipate a material change in the fair value of the debentures based on the current market for them.

Our outstanding financing obligations related to the sale-leaseback transaction are not publicly traded and are not subject to fluctuations in interest rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

INDEX TO FINANCIAL STATEMENTS

MANAGEMENT REPORT ON CONSOLIDATED FINANCIAL STATEMENTS

The management of Sierra Health Services, Inc. is responsible for the integrity and objectivity of the accompanying consolidated financial statements. The statements have been prepared in conformity with accounting principles generally accepted in the United States of America applied on a consistent basis and are not misstated due to fraud or material error. The statements include some amounts that are based upon the Company's best estimates and judgment.

The accounting systems and controls of the Company are designed to provide reasonable assurance that transactions are executed in accordance with management's authorization, that the financial records are reliable for preparing financial statements and maintaining accountability for assets, and

that assets are safeguarded against losses from unauthorized use or disposition. Management believes that for the year ended December 31, 2001, such systems and controls were adequate to meet the objectives discussed herein.

The accompanying consolidated financial statements have been audited by independent certified public accountants, whose audits thereof were made in accordance with auditing standards generally accepted in the United States of America and included a review of internal accounting controls to the extent necessary to design audit procedures aimed at gathering sufficient evidence to provide a reasonable basis for their opinion on the fairness of presentation of the consolidated financial statements taken as a whole.

The Audit Committee of the Board of Directors, comprised solely of directors from outside the Company, meets regularly with management and the independent auditors to review the work procedures of each. The independent auditors have free access to the Audit Committee, without management being present, to discuss the results of their opinions on the adequacy of the Company's accounting controls and the quality of the Company's financial reporting. The Board of Directors, upon the recommendation of the Audit Committee, appoints the independent auditors, subject to stockholder ratification.

Anthony M. Marlon, M.D.
Chairman and Chief Executive Officer

Paul H. Palmer
Vice President, Finance
Chief Financial Officer and Treasurer

INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholders of
Sierra Health Services, Inc.:

We have audited the accompanying consolidated balance sheets of Sierra Health Services, Inc. and its subsidiaries as of December 31, 2001 and 2000, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2001. Our audits also included the financial statement schedules listed in the Index at Item 14 (a)(2). These financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and financial statement schedules based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a

reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Sierra Health Services, Inc. and its subsidiaries at December 31, 2001 and 2000, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2001 in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly in all material respects the information set forth therein.

DELOITTE & TOUCHE LLP
Las Vegas, Nevada
January 30, 2002

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
December 31, 2001 and 2000
(In thousands, except per share data)

ASSETS

	2001
CURRENT ASSETS:	
Cash and Cash Equivalents	$ 115,7
Investments	260,7
Accounts Receivable (Less: Allowance for Doubtful Accounts 2001 - $12,655; 2000 - $12,587)	26,0
Military Accounts Receivable (Less: Allowance for Doubtful Accounts 2001 - $0; 2000 - $1,212)	40,1
Current Portion of Deferred Tax Asset	35,8
Current Portion of Reinsurance Recoverable	96,7
Other Current Receivables	16,8
Prepaid Expenses and Other Current Assets	14,8
Assets Held for Sale	
Assets of Discontinued Operations	28,4
Total Current Assets	635,3
PROPERTY AND EQUIPMENT, NET	141,4
LONG-TERM INVESTMENTS	8,4
RESTRICTED CASH AND INVESTMENTS	26,0
REINSURANCE RECOVERABLE (Less Current Portion)	123,3
GOODWILL (Less: Accumulated Amortization 2001 - $6,972; 2000 - $6,167)	14,7
DEFERRED TAX ASSET (Less Current Portion)	77,0
OTHER ASSETS	43,5
TOTAL ASSETS	$1,069,9

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES:	
Accrued Liabilities	$ 53,5
Trade Accounts Payable	21,5

Accrued Payroll and Taxes	14,3
Medical Claims Payable	81,6
Current Portion of Reserve for Losses and Loss Adjustment Expenses	142,3
Unearned Premium Revenue	52,9
Military Health Care Payable	77,2
Current Portion of Long-term Debt	1,6
Liabilities of Discontinued Operations	83,9
Total Current Liabilities	529,2
RESERVE FOR LOSSES AND LOSS ADJUSTMENT EXPENSE (Less Current Portion)	243,3
LONG-TERM DEBT (Less Current Portion)	181,7
OTHER LIABILITIES	19,0
TOTAL LIABILITIES	973,4
COMMITMENTS AND CONTINGENCIES	
STOCKHOLDERS' EQUITY:	
Preferred Stock, $.01 Par Value, 1,000 Shares Authorized; None Issued or Outstanding	
Common Stock, $.005 Par Value, 60,000 Shares Authorized; Shares Issued: 2001 - 29,648; 2000 - 28,815	1
Additional Paid-In Capital	181,0
Deferred Compensation	(1,0
Treasury Stock: 2001 and 2000 - 1,523 Common Stock Shares	(22,7
Accumulated Other Comprehensive Loss	(5,6
Accumulated Deficit	(55,2
TOTAL STOCKHOLDERS' EQUITY	96,5
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$1,069,9

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
For the Years Ended December 31, 2001, 2000 and 1999
(In thousands, except per share data)

	2001	200
OPERATING REVENUES:		
Medical Premiums	$ 718,994	$ 637,
Military Contract Revenues	338,918	330,
Specialty Product Revenues	183,306	135,
Professional Fees	28,985	33,
Investment and Other Revenues	21,298	22,
Total	1,291,501	1,159,
OPERATING EXPENSES:		
Medical Expenses	608,757	576,
Military Contract Expenses	331,621	323,

Specialty Product Expenses	188,574	152,
General, Administrative and Marketing Expenses	117,717	105,
Asset Impairment, Restructuring, Reorganization and Other Costs		33,
Total	1,246,669	1,191,
OPERATING INCOME (LOSS) FROM CONTINUING OPERATIONS	44,832	(32,
INTEREST EXPENSE AND OTHER, NET	(18,563)	(19,
INCOME (LOSS) FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	26,269	(51,
(PROVISION) BENEFIT FOR INCOME TAXES	(8,803)	12,
NET INCOME (LOSS) FROM CONTINUING OPERATIONS	17,466	(38,
LOSS FROM DISCONTINUED OPERATIONS (net of income tax benefit of $7,046, $61,350 and $8,144)	(13,980)	(161,
NET INCOME (LOSS)	$ 3,486	$ (199,
EARNINGS PER COMMON SHARE:		
Net Income (Loss) From Continuing Operations	$0.63	$(1
Loss from Discontinued Operations	(0.50)	(5
Net Income (Loss)	$0.13	$(7
EARNINGS PER COMMON SHARE ASSUMING DILUTION:		
Net Income (Loss) From Continuing Operations	$0.61	$(1
Loss from Discontinued Operations	(0.49)	(5
Net Income (Loss)	$0.12	$(7

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2001, 2000 and 1999
(In thousands)

	Common Stock Shares	Common Stock Amount	Addi-tional Paid-In Capital	Deferred Compen-sation	T
BALANCE, JANUARY 1, 1999	28,236	$141	$173,583	-	$
Comprehensive Income:					
Net Loss					

Other Comprehensive Loss, Net of Tax:					
Unrealized Holding Loss on Available-for-sale Investments.					
Reclassification Adjustment for Losses Included in Net Loss					
Comprehensive Loss.....					
Common Stock Issued in Connection with Stock Plans.....	164	1	2,331		
Purchase of Treasury Stock.....					
Income Tax Benefit Realized Upon Exercise of Stock Options...			1		
BALANCE, DECEMBER 31, 1999.....	28,400	142	175,915	-	
Comprehensive Income:					
Net Loss.....					
Other Comprehensive Loss, Net of Tax:					
Unrealized Holding Gain on Available-for-sale Investments.					
Reclassification Adjustment for Gains Included in Net Loss					
Comprehensive Loss.....					
Common Stock Issued in Connection with Stock Plans.....	415	2	1,578		
BALANCE, DECEMBER 31, 2000.....	28,815	144	177,493	-	
Comprehensive Income:					
Net Income					
Other Comprehensive Loss, Net of Tax:					
Unrealized Holding Gain on Available-for-sale Investments					
Reclassification Adjustment for Gains Included in Net Loss					
Comprehensive Income.....					
Issuance of Restricted Stock...	244	1	1,399	$(1,400)	
Amortization of Deferred Compensation				342	
Common Stock Issued in Connection with Stock Plans.....	589	3	2,087		
Income Tax Benefit Realized Upon Exercise of Stock Options...			97		
BALANCE, DECEMBER 31, 2001.....	29,648	$148	$181,076	$(1,058)	$

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2001, 2000 and 1999
(In thousands)

	Accumulated Other Comprehensive (Loss)	**Comprehensive (Loss)**	**Retained Earnings (Accumulated**	**To St hol**

	Income	Income	Deficit)	Eq
BALANCE, JANUARY 1, 1999.....	$ (1,027)		$ 145,838	$ 30
Comprehensive Income:				
Net Loss.....		$ (4,631)	(4,631)	(
Other Comprehensive Loss, Net of Tax:				
Unrealized Holding Loss on Available-for-sale Investments...	(15,295)	(15,295)		(1
Reclassification Adjustment for Losses Included in Net Loss	259	259		
Comprehensive Loss.....		$(19,667)		
Common Stock Issued in Connection with Stock Plans.....				
Purchase of Treasury Stock.....				(
Income Tax Benefit Realized Upon Exercise of Stock Options...				
BALANCE, DECEMBER 31, 1999.....	(16,063)		141,207	27
Comprehensive Income:				
Net Loss.....		$(199,915)	(199,915)	(19
Other Comprehensive Loss, Net of Tax:				
Unrealized Holding Gain on Available-for-sale Investments	11,092	11,092		1
Reclassification Adjustment for Gains Included in Net Loss	(696)	(696)		
Comprehensive Loss.....		$(189,519)		
Common Stock Issued in Connection with Stock Plans.....				
BALANCE, DECEMBER 31, 2000.....	(5,667)		(58,708)	9
Comprehensive Income:				
Net Income.....		$ 3,486	3,486	
Other Comprehensive Loss, Net of Tax:				
Unrealized Holding Gain on Available-for-sale Investments	243	243		
Reclassification Adjustment for Gains Included in Net Loss	(212)	(212)		
Comprehensive Income.....		$ 3,517		
Issuance of Restricted Stock...				
Amortization of Deferred Compensation				
Common Stock Issued in Connection with Stock Plans.....				
Income Tax Benefit Realized Upon Exercise of Stock Options...				
BALANCE, DECEMBER 31, 2001.....	$ (5,636)		(55,222)	$ 9

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 2001, 2000 and 1999
(In thousands)

	2001	2
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net Income (Loss)	$ 3,486	$(1
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided by (Used for) Operating Activities:		
Loss from Discontinued Operations	13,980	1
Depreciation and Amortization	25,547	
Deferred Compensation Expense	342	
Provision for Doubtful Accounts	1,232	
Provision for Asset Impairment		
Loss on Property and Equipment Dispositions	2,418	
Change in Assets and Liabilities:		
Other Assets	(1,863)	
Deferred Tax Asset	2,029	(
Reinsurance Recoverable	31,559	(1
Reserve for Losses and Loss Adjustment Expenses	11,151	1
Other Liabilities	2,646	
Accounts Receivable	(1,786)	
Other Current Assets	(639)	
Military Accounts Receivable	32,436	(
Military Health Care Payable	(7,598)	
Medical Claims Payable	7,258	
Other Current Liabilities	2,275	(
Net Cash Provided by (Used for) Continuing Operations	124,473	
CASH FLOWS FROM INVESTING ACTIVITIES:		
Capital Expenditures	(9,462)	(
Property and Equipment Dispositions	7,293	
Purchase of Available-for-Sale Investments	(849,061)	(2
Proceeds from Sales/Maturities of Available-for-Sale Investments	790,611	2
Purchase of Held-to-Maturity Investments	(1,265)	
Proceeds from Maturities of Held-to-Maturity Investments	8,585	
Net Cash (Used for) Provided by Continuing Operations	(53,299)	
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from Long-term Borrowing		
Payments on Debt and Capital Leases	(81,041)	(
Purchase of Treasury Stock		
Exercise of Stock in Connection with Stock Plans	2,090	
Net Cash (Used for) Provided by Continuing Operations	(78,951)	
NET CASH (USED FOR) PROVIDED BY DISCONTINUED OPERATIONS	(34,033)	
NET (DECREASE) INCREASE IN CASH AND		

CASH EQUIVALENTS	(41,810)	1
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	157,564	
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 115,754	$ 1

See the accompanying notes to consolidated financial statements.

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
For the Years Ended December 31, 2001, 2000 and 1999

1. BUSINESS

Business. The consolidated financial statements include the accounts of Sierra Health Services, Inc. and its subsidiaries (collectively referred to as "Sierra" or the "Company"). Sierra is a managed health care organization that provides and administers the delivery of comprehensive health care and workers' compensation programs with an emphasis on quality care and cost management. Sierra's broad range of managed health care services is provided through its health maintenance organizations ("HMOs"), managed indemnity plans, military health services programs, third-party administrative services programs for employer-funded health benefit plans and its workers' compensation insurance and medical management programs. Ancillary products and services that complement the Company's managed health care product lines are also offered.

During the third quarter of 2001, the Company announced its plan to exit the Texas HMO health care market and received formal approval from the Texas Department of Insurance to withdraw its HMO operations in mid-October. The Company will cease providing HMO health care coverage in Texas on April 17, 2002. In accordance with Statement of Financial Accounting Standards No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" ("SFAS No. 144"), the Company's Texas HMO health care operations have been reclassified as discontinued operations. The individual line items on the consolidated balance sheets have been presented net of discontinued operations with the total assets and liabilities of the discontinued operations presented on one line within current assets and current liabilities, respectively. The results of operations from discontinued operations have been reported net of tax as a separate component of income on the consolidated statements of operations. The cash flows from discontinued operations have been reported as a separate component on the consolidated statements of cash flows. See Note 10 for disclosure on and a description of the discontinued operations.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation. All significant intercompany transactions and balances have been eliminated. Sierra's consolidated subsidiaries include: Health Plan of Nevada, Inc. ("HPN") and Texas Health Choice, L.C. ("TXHC"), which are licensed HMOs; Sierra Health and Life Insurance Company, Inc. ("SHL"), a health and life insurance company; Southwest Medical Associates, Inc. ("SMA"), a multi-specialty medical provider group; Sierra Military Health Services, Inc., and its subsidiary, ("SMHS"), a company that provides and administers managed care services to certain TRICARE eligible beneficiaries; CII Financial, Inc. ("CII"), a holding company primarily engaged in writing workers' compensation

insurance through its wholly-owned subsidiaries; administrative services companies; a home health care agency; a hospice; a home medical products subsidiary; and a company that provides and manages mental health and substance abuse services. TXHC is reported as part of discontinued operations.

Medical Premiums. Membership contracts are generally established on an annual basis subject to cancellation by the employer group or Sierra generally upon 60 days written notice. Premiums, including premiums from both commercial and governmental programs, are due monthly and are recognized as revenue during the period in which Sierra is obligated to provide services to members and are net of estimated retroactive terminations of members and groups. Non-Medicare member enrollment is represented principally by employer groups. HPN offers a prepaid health care program to Medicare recipients. Revenues associated with Medicare recipients were approximately $304,734,000, $267,851,000 and $242,753,000 in 2001, 2000 and 1999, respectively. Unearned premium revenue includes payments under prepaid Medicare contracts with the Centers for Medicare and Medicaid Services ("CMS") and prepaid HPN commercial and SHL indemnity premiums.

Military Contract Revenues. Revenue under the Department of Defense TRICARE contract is recorded based on the contract price as agreed to by the federal government. The contract also contains provisions which adjust the contract price based on actual experience and for government-directed change orders. The estimated effects of these adjustments are recognized on a monthly basis. In addition, the Company records revenue based on estimates of the earned portion of any contract change orders not originally specified in the contract.

Specialty Product Revenues. These revenues consist primarily of workers' compensation premiums. Premiums are calculated by formula such that the premium written is earned pro rata over the term of the policy. Also included in specialty product revenues are administrative services fees and certain ancillary product revenues. Such revenues are recognized in the period in which the service is performed or the period that coverage for services is provided. Premiums written in excess of premiums earned are recorded as an unearned premium revenue liability. Premiums earned include an estimate for earned but unbilled premiums.

Professional Fees. Revenue for professional medical services is recorded on the accrual basis in the period in which the services are provided. Such revenue is recorded at established rates, net of provisions for estimated contractual allowances.

Medical Expenses. The Company contracts with hospitals, physicians and other independently contracted providers of health care under capitated or discounted fee-for-service arrangements including hospital per diems to provide medical care services to enrollees. Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees in the relevant geographic areas; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services. Health care costs are recorded in the period when services are provided to enrolled members, including estimates for provider costs which have been incurred as of the balance sheet date but not reported to the Company. Any subsequent changes in estimate for a prior year would be reflected in the current year's operating results.

Military Contract Expenses. This expense consists primarily of costs to provide managed health care services to eligible beneficiaries in accordance with the Company's TRICARE contract. Under the contract, SMHS provides health care services to approximately 639,000 dependents of active duty military personnel and military retirees and their dependents through subcontractor partnerships and individual providers. Health care costs are recorded in the period when services are provided to eligible beneficiaries including estimates for provider costs which have been incurred as of the balance sheet date but not reported to

the Company. Also included in military contract expenses are costs incurred to perform specific administrative services, such as health care appointment scheduling, enrollment, network management and health care advice line services and other administrative functions of the military health care subsidiary.

Specialty Product Expenses. This expense consists primarily of losses and loss adjustment expense ("LAE"), policy acquisition costs and other general and administrative expenses associated with issued workers' compensation policies. Losses and LAE are based upon the accumulation of cost estimates for reported claims occurring during the period as well as an estimate for losses that have occurred but have not yet been reported. Policy acquisition costs consist of commissions, premium taxes and other underwriting costs, which are directly related to the production and retention of new and renewal business and are deferred and amortized as the related premiums are earned. Should it be determined that future policy revenues and earnings on invested funds relating to existing insurance contracts will not be adequate to cover related costs and expenses, deferred costs are expensed. Also included in specialty product expenses are costs associated with administrative services and certain ancillary products. These costs are recorded when incurred.

Loss and LAE reserves have a significant degree of uncertainty when related to their subsequent payments. Although reserves are established on the basis of a reasonable estimate, it is not only possible but probable that reserves will differ from their related subsequent developments. Underlying causes for this uncertainty include, but are not limited to, uncertainty in development patterns and unanticipated inflationary trends affecting the services covered by the insurance contract. This uncertainty can result in both adverse as well as favorable development of actual subsequent activity when compared to the reserve established. Any subsequent change in loss and LAE reserves established in a prior year would be reflected in the current year's operating results.

Cash and Cash Equivalents. The Company considers cash and cash equivalents as all highly liquid instruments with a maturity of three months or less at time of purchase. The carrying amount of cash and cash equivalents approximates fair value because of the short maturity of these instruments.

Investments. Investments consist principally of U.S. Government and its agencies securities and municipal bonds, as well as corporate and mortgage-backed securities. All non-restricted investments that are designated as available-for-sale are classified as current assets. These investments are available for use in the current operations regardless of contractual maturity dates. Non-restricted investments designated as held-to-maturity are classified as current assets if expected maturity is within one year of the balance sheet date. Otherwise, they are classified as long-term investments. Realized gains and losses are calculated using the specific identification method and are included in net income. Unrealized holding gains and losses on available-for-sale securities are included as a separate component of stockholders' equity until realized.

Restricted Cash and Investments. Certain subsidiaries are required by state regulatory agencies to maintain deposits and must also meet net worth and reserve requirements. The Company believes its subsidiaries are in compliance with the applicable minimum regulatory and capital requirements.

Military Accounts Receivable. Amounts receivable under government contracts are comprised primarily of estimates of adjustments under the contract based on actual experience and estimates of the earned portion of any change orders not originally specified in the contract.

During 2001, SMHS adopted SFAS No. 140, "Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities", which provides accounting and reporting standards for securitizations and other transfers of

financial assets and extinguishments of liabilities. On November 16, 2001, SMHS entered into a securitization arrangement with General Electric Capital Corporation. The arrangement provides for the sale of SMHS' Federal Government accounts receivable to SMHS Funding, LLC. SMHS Funding is a special purpose limited liability company owned by SMHS and was formed for the purpose of purchasing all receivables of SMHS. This entity is fully consolidated into SMHS. SMHS Funding, LLC may sell an undivided interest in certain of the receivables to a subsidiary of General Electric Capital Corporation in the event that additional financing by SMHS is warranted.

As of and for the year ended December 31, 2001, SMHS has not utilized the facility and is currently incurring an unused facility fee of 0.5% per annum calculated daily and payable monthly in arrears on the unused portion of the maximum purchase limit of $32 million. As the servicer, SMHS receives servicing fees at the rate of 1.0% per annum on the capital investment.

Reinsurance Recoverable. In the normal course of business, the Company seeks to reduce the effects of catastrophic and other events that may cause unfavorable underwriting results by reinsuring certain levels of risk with other reinsurers. Reinsurance recoverable for ceded paid claims is recorded in accordance with the terms of the agreements and reinsurance recoverable for unpaid losses and LAE and medical claims payable is estimated in a manner consistent with the claim liability associated with the reinsurance policy. Reinsurance receivables, including amounts related to paid and unpaid losses, are reported as assets rather than a reduction of the related liabilities.

Property and Equipment. Property and equipment are stated at cost less accumulated depreciation. Maintenance and repairs that do not significantly improve or extend the life of the respective assets are charged to operations. Depreciation and amortization is computed using the straight-line method over the estimated service lives of the assets or terms of leases if shorter. Estimated useful lives are as follows:

Buildings and Improvements	10 - 30 years
Leasehold Improvements	3 - 10 years
Furniture, Fixtures and Equipment	3 - 5 years
Data Processing Hardware and Software	3 - 10 years

Goodwill. Goodwill has been recorded primarily as a result of various business acquisitions by the Company. Amortization has been recorded on a straight line basis over periods not exceeding 40 years. The Company has periodically evaluated the carrying value of its intangible assets. The Company utilized the discounted cash flow method for evaluating the recoverability of goodwill. Future cash flows are estimated based on Company projections and are discounted based on the interest rates approximating long-term bond yields.

In connection with the restructuring plans adopted and announced by the Company in the second quarter of 2000, the Company re-evaluated the recoverability of certain long-lived assets, primarily those associated with the Texas HMO health care operations, in accordance with Statement of Financial Accounting Standards No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of" ("SFAS No. 121") and Accounting Principles Board Opinion No. 17, "Intangible Assets" ("APB No. 17"), and determined that the carrying value of certain goodwill was impaired. In assessing the asset impairment of the long-lived assets, the Company first allocated a portion of related goodwill to the fixed assets to be disposed of, in accordance with SFAS No. 121. The remainder of the related goodwill was then assessed for recoverability in accordance with APB No. 17 based on projected discounted cash flows and an impairment of $141,506,000 was recorded. Of the total impairment, $126,387,000 was related to and has been recorded as part of discontinued operations. See Note 10 and Note 17 for a description of the primary facts and circumstances related to the impairment.

Starting in 2002, goodwill will be evaluated in accordance with Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets" ("SFAS No. 142"), which is effective January 1, 2002. In accordance with SFAS No. 142, the Company will no longer amortize its goodwill. Amortization expense, from continuing operations, associated with goodwill was $805,000, $1,131,000 and $1,463,000 for the years ended December 31, 2001, 2000 and 1999, respectively.

Medical Claims Payable and Military Health Care Payable. Medical claims payable and military health care payable include the estimated cost for unpaid claims for which health care services have been provided to enrollees and to TRICARE eligibles. Such provisions include an estimate for the costs of claims that have been incurred but have not been reported.

Premium Deficiency Reserves. Premium deficiency expenses are recognized when it is probable that the future costs associated with a group of existing contracts will exceed the anticipated future premiums on those contracts. The Company calculates expected premium deficiency expense based on budgeted revenues and expenses. Premium deficiency reserves are evaluated quarterly for adequacy. See Note 10 and Note 16 for a description of premium deficiency expenses and balances for the years ended December 31, 2001, 2000 and 1999. The premium deficiency accruals as of December 31, 2001 and 2000 were related to the discontinued operations.

Reserve for Losses and Loss Adjustment Expense. The reserve for workers' compensation losses and LAE consists of estimated costs of each unpaid claim reported to the Company prior to the close of the accounting period, as well as those incurred but not yet reported. The methods for establishing and reviewing such liabilities are continually reviewed and adjustments are reflected in current operations. The Company does not discount its losses and LAE reserves.

Income Taxes. The Company accounts for income taxes using the liability method. Deferred income tax assets and liabilities result from temporary differences between the tax basis of assets and liabilities and the reported amounts in the consolidated financial statements that will result in taxable or deductible amounts in future years. The Company's temporary differences arise principally from certain net operating losses, accrued expenses, reserves, depreciation and impairment charges.

Concentration of Credit Risk. The Company's financial instruments that are exposed to credit risk consist primarily of investments and accounts receivable. The Company maintains cash and cash equivalents and investments with various financial institutions. These financial institutions are located in many different regions and company policy is designed to limit exposure with any one institution.

Credit risk with respect to accounts receivable is generally diversified due to the large number of entities comprising the Company's customer base and their dispersion across many different industries. These customers are primarily located in the states in which the Company operates and are principally in California, Nevada and Texas. However, the Company is licensed and does business in several other states. As of December 31, 2001, the Company had receivables outstanding from the federal government related to its TRICARE contract in the amount of $40.2 million. The Company also has receivables from its reinsurers. Reinsurance contracts do not relieve the Company from its obligations to enrollees or policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company. The Company evaluates the financial condition of its reinsurers to minimize its exposure to significant losses from reinsurer insolvencies. All reinsurers with whom the Company has reinsurance contracts are rated AA and A+ or better by Fitch Ratings and the A.M. Best Company, respectively.

Derivatives. The Company's only derivative instrument is an interest rate swap agreement used to minimize interest rate risk. As of January 1, 2001, the Company implemented Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS No. 133"). The implementation did not result in an adjustment. At December 31, 2001 we recorded the swap agreement to its fair market value. The fair market value was determined based on what the Company would need to pay, $685,000, to terminate the swap agreement at December 31, 2001. Sierra accounts for derivative instruments on the balance sheet at fair value with changes in fair values reported as part of net income.

Recently Issued Accounting Standards. In July 2001, the FASB issued SFAS No. 142 which is effective January 1, 2002. SFAS No. 142 requires, among other things, the discontinuance of goodwill amortization. In addition, the pronouncement includes provisions for the reclassification of certain existing recognized intangibles as goodwill, reassessment of the useful lives of existing recognized intangibles, reclassification of certain intangibles out of previously reported goodwill and the identification of reporting units for purposes of assessing potential future impairments of goodwill. SFAS No. 142 also requires us to complete a transitional goodwill impairment test six months from the date of adoption. The net amortized goodwill balance at December 31, 2001 was $14.8 million and goodwill amortization expense during the year was $805,000 and would have been approximately the same amount in 2002 under current accounting standards. The Company has performed an evaluation of the impact of SFAS No. 142 on our operations and has determined that the recorded goodwill was not impaired under the guidelines of the pronouncement.

In October 2001, the FASB issued SFAS No. 144 which is effective for fiscal years beginning after December 15, 2001 with early adoption recommended. SFAS No. 144 requires that long-lived assets that are to be sold within one year must be separately identified and carried at the lower of carrying value or fair value less costs to sell. Long-lived assets expected to be held longer than one year are subject to depreciation and must be written down to fair value upon impairment. Long-lived assets no longer expected to be sold within one year, such as foreclosed real estate, must be written down to the lower of current fair value or fair value at the date of foreclosure adjusted to reflect depreciation since acquisition. As discussed in Note 4 of Notes to the Consolidated Financial Statements the Company elected to adopt early SFAS No. 144 effective January 1, 2001 and present the Texas HMO health care operations as discontinued.

Use of Estimates and Assumptions in the Preparation of Financial Statements. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Management must exercise its judgment taking into consideration the facts and circumstances in selecting assumptions and other factors in calculating its estimates. On an on-going basis, management re-evaluates its assumptions and the methods of calculating its estimates. Estimates and assumptions include, but are not limited to, medical and specialty product expenses, military revenue and expenses and goodwill recoverability. Actual results may materially differ from estimates.

Reclassifications. Certain amounts in the Consolidated Financial Statements for the years ended December 31, 2000 and 1999 have been reclassified to conform with the current year presentation.

3. EARNINGS PER SHARE

The following table provides a reconciliation of basic and diluted earnings per share ("EPS"):

(In thousands, except per share data)	Years ended De	
	2001	**200**
Income (loss) from continuing operations	$ 17,466	$ (38,
Loss from discontinued operations	(13,980)	(161,
Net income (loss)	$ 3,486	$ (199,
Earnings per common share:		
Income (loss) from continuing operations	$ 0.63	$ (1
Loss from discontinued operations	(0.50)	(5
Net income (loss)	$ 0.13	$ (7
Earnings per common share assuming dilution:		
Income (loss) from continuing operations	$ 0.61	$ (1
Loss from discontinued operations	(0.49)	(5
Net income (loss)	$ 0.12	$ (7
Weighted average common shares outstanding	27,685	27,
Weighted average common shares outstanding assuming dilution	28,509	27,

Options to purchase 4,250,000 shares of common stock were outstanding at December 31, 2000 but were not included in the computation of diluted earnings per share because the Company had a net operating loss for the year and their inclusion would have been anti-dilutive.

CII issued convertible subordinated debentures (the "Debentures") due September 15, 2001. Each $1,000 in principal was convertible into 25.382 shares of the Company's common stock at a conversion price of $39.398 per share. The Debentures were paid off in September 2001 and they have not been included in the computation of EPS during the years presented because their effect would be anti-dilutive.

4. PROPERTY AND EQUIPMENT

Property and equipment at December 31, consists of the following:

(In thousands)	**2001**
Land	$ 11,263
Buildings and Improvements	101,822
Furniture, Fixtures and Equipment	39,565
Data Processing Equipment and Software	96,405
Software in Development and Construction in Progress	2,424
Less: Assets Held for Sale	

Accumulated Depreciation	(110,028)
Property and Equipment, Net.....	$ 141,451

The following is an analysis of property and equipment under capital lease by classification as of December 31:

(In thousands):	2001
Data Processing Equipment and Software	$ 333
Furniture, Fixtures and Equipment.....	
Buildings.....	245
Less: Accumulated Depreciation.....	(316)
Property and Equipment, Net.....	$ 262

The Company capitalizes interest expense as part of the cost of construction of facilities and the implementation of computer systems. Interest expense capitalized in 2001, 2000 and 1999 was $29,000, $67,000 and $2,140,000, respectively. Depreciation expense, from continuing operations, in 2001, 2000 and 1999 was $24,742,000, $23,847,000 and $18,961,000, respectively.

Assets held for sale on the balance sheet at December 31, 2000 consisted of real estate in Arizona which the Company sold during 2001.

Sale-Leaseback. On December 28, 2000, the Company sold the majority of its Las Vegas, Nevada administrative and medical clinic real estate holdings in a sale-leaseback transaction. As part of the transaction, the Company financed a portion of the sales price with mortgage notes receivable of $22.2 million and provided deposits of $4.3 million. The mortgages and deposits constitute continuing involvement as defined in Statement of Financial Accounting Standards No. 98, "Accounting for Leases" ("SFAS No. 98"), and as such the transaction did not qualify as a sale. In accordance with SFAS No. 98, the Company recorded the transaction as a financing obligation of $113,659,000, offset by the mortgage notes receivable of $22,200,000. The net book value of the assets included in the transaction was $86,890,000 at December 31, 2000. For assets that do not qualify for sale treatment, depreciation expense and interest expense are recognized on the net book value of the assets and net financing obligation outstanding, respectively.

During 2001, the Company received full payment on the outstanding mortgage notes receivable associated with three of the medical clinics. This cured the continuing involvement criteria from SFAS No. 98 and the clinics then qualified as a sale. To record the sale, the Company retired the assets and their associated accumulated depreciation and financing obligation and recorded a deferred gain to be recognized over the remaining 14 year term of the lease. The impact of the sale of the three clinics was a net reduction of $13.4 million in property and equipment, a net reduction of $14.6 million in the associated financing obligation and a deferred gain of $6.1 million. As of December 31, 2001, the remaining financing obligation was $90,810,000, offset by mortgage notes receivable of $16,862,000.

The Company expects that the remaining mortgages and deposits will be repaid to Sierra by the end of 2002, at which time the rest of the transaction will qualify as a sale.

5. CASH AND INVESTMENTS

Investments that the Company has the intention and ability to hold to maturity are stated at amortized cost and categorized as held-to-maturity. The remaining

investments have been categorized as available-for-sale and are stated at their fair value. Fair value is estimated primarily from published market values as of the balance sheet date. Gross realized gains on investments for 2001, 2000 and 1999 were $1,098,000, $494,000 and $334,000, respectively. Gross realized losses on investments for 2001, 2000 and 1999 were $771,000, $1,566,000 and $733,000, respectively.

The following table summarizes the Company's current, long-term and restricted investments as of December 31, 2001:

(In thousands)	Amortized Cost	Gross Unrealized Gains	
Available-for-Sale Investments:			
Classified as Current:			
U.S. Government and its Agencies	$210,949	$1,129	
Municipal Obligations	16,274	31	
Corporate Bonds	29,572	81	
Other	851		
Total Debt Securities	257,646	1,241	
Preferred Stock	8,884	40	
Total Current	266,530	1,281	
Classified as Restricted:			
U.S. Government and its Agencies	17,677	352	
Municipal Obligations	2,326	38	
Corporate Bonds	1,495	35	
Other	2,029		
Total Restricted	23,527	425	
Total Available-for-Sale	$290,057	$1,706	
Held-to-Maturity Investments:			
Classified as Current:			
Corporate Bonds	$ 2,999	$ 22	
Classified as Long-term:			
U.S. Government and its Agencies	5,608		
Municipal Obligations	328		
Corporate Bonds	2,498	175	
Total Long-term	8,434	175	
Classified as Restricted:			
U.S. Government and its Agencies	626	24	
Municipal Obligations	636		
Corporate Bonds	1,114	42	

Total Restricted	2,376	66
Total Held-to-Maturity	$ 13,809	$ 263

The following table summarizes the Company's current, long-term and restricted investments as of December 31, 2000:

(In thousands)	Amortized Cost	Gross Unrealized Gains
Available-for-Sale Investments:		
Classified as Current:		
U.S. Government and its Agencies	$145,610	$284
Municipal Obligations	20,303	41
Corporate Bonds	41,040	62
Total Debt Securities	206,953	387
Preferred Stock	7,957	50
Total Current	214,910	437
Classified as Restricted:		
U.S. Government and its Agencies	15,862	69
Municipal Obligations	2,637	49
Corporate Bonds	1,192	16
Other	2,509	
Total Restricted	22,200	134
Total Available-for-Sale	$237,110	$571
Held-to-Maturity Investments:		
Classified as Current:		
U.S. Government and its Agencies	$ 283	$ 3
Municipal Obligations	505	12
Total Current	788	15
Classified as Long-term:		
U.S. Government and its Agencies	11,230	262
Municipal Obligations	2,381	53
Corporate Bonds	4,482	117
Total Long-term	18,093	432
Classified as Restricted:		
U.S. Government		

and its Agencies	1,263	14
Corporate Bonds	499	23
Other	615	
Total Restricted	2,377	37
Total Held-to-Maturity	$ 21,258	$484

The contractual maturities of available-for-sale investments at December 31, 2001 are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations.

(In thousands)	Amortized Cost
Due in one year or less	$ 13,590
Due after one year through five years	39,511
Due after five years through ten years	34,345
Due after ten years through fifteen years	19,399
Due after fifteen years	174,328
Total	$281,173

The contractual maturities of held-to-maturity investments at December 31, 2001 are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations.

(In thousands)	Amortized Cost
Due in one year or less	$ 4,065
Due after one year through five years	3,171
Due after five years through ten years	
Due after ten years through fifteen years	
Due after fifteen years	6,573
Total	$13,809

Of the cash and cash equivalents and current investments that total $376.5 million in the accompanying Consolidated Balance Sheet at December 31, 2001, $341.3 million is limited for use only by the Company's regulated subsidiaries. Such amounts are available for transfer to Sierra from the regulated subsidiaries only to the extent that they can be remitted in accordance with terms of existing management agreements and by dividends, which customarily must be approved by regulating state insurance departments. The remainder is available to Sierra on an unrestricted basis.

6. REINSURANCE

The Company is covered under medical reinsurance agreements that provide coverage for 50% - 90% of hospital and other costs in excess of, depending on the contract, $75,000 to $200,000 per case, up to a maximum of $2,000,000 per member per lifetime for both the managed indemnity and HMO subsidiaries. In addition, certain of the Company's HMO members are covered by an excess

catastrophe reinsurance contract and SHL maintains reinsurance on certain of its insurance products. Reinsurance premiums of $1,680,000, $2,433,000 and $1,835,000, net of reinsurance recoveries of $1,760,000, $1,945,000 and $1,761,000, are included in medical expenses for 2001, 2000 and 1999, respectively.

CII has reinsurance agreements or treaties in effect with unrelated entities. Effective July 1, 1998, all claims with dates of injury occurring on or after that date were reinsured under a quota share and excess of loss agreement, "low level reinsurance", with Travelers Indemnity Company of Illinois ("Travelers"). Travelers is rated AA and A++ by Fitch Ratings and the A.M. Best Company, respectively. The low level reinsurance provided quota share protection for 30% of the first $10,000 of each loss, and excess of loss protection of 75% of the next $40,000 of each loss, and 100% of the next $450,000 on a per occurrence basis. The maximum net loss retained on any one claim ceded under this treaty was $17,000. This agreement continued until June 30, 2000, when CII exercised an option for a twelve month extension relating to the run-off of policies in force as of June 30, 2000, which covered claims arising under such policies during the term of the extension.

In addition to the low level reinsurance, effective January 1, 2000 CII entered into a reinsurance contract that provides statutory (unlimited) coverage for workers' compensation claims in excess of $500,000 per occurrence. The contract is in effect for claims occurring on or after January 1, 2000 through December 31, 2002. There is a twelve month run out provision in the contract which the Company intends to exercise. The reinsurer, National Union Fire Insurance Company, is rated AAA and A++ by Fitch Ratings and the A.M. Best Company, respectively.

Effective July 1, 2000, CII entered into a reinsurance contract with National Union Fire Insurance Company that provided $250,000 of coverage for workers' compensation claims in excess of $250,000 per occurrence. The contract was in effect for claims occurring on policies with effective dates beginning July 1, 2000 and thereafter and for claims incurred prior to July 1, 2001.

The low level reinsurance agreement was consummated early in the fourth quarter of 1998 but coverage was made retroactive to July 1, 1998. Therefore, this agreement contained both retroactive (covering claims occurring in the third calendar quarter of 1998) and prospective reinsurance coverage (covering claims occurring after September 30, 1998). In accordance with Statement of Financial Accounting Standards No. 113, "Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts" ("SFAS No. 113"), the Company bifurcated the low level reinsurance agreement between the retroactive and prospective components due to the different accounting treatments for each respective piece. The amount by which the estimated ceded liabilities exceeded the amount paid for the retroactive coverage was reported as a deferred gain and is amortized to income as a reduction of incurred losses over the estimated remaining settlement period using the interest method. Any subsequent changes in estimated or actual cash flows related to the retroactive coverage are accounted for by adjusting the previously recorded deferred gain to the balance that would have existed had the revised estimate been available at the inception of the reinsurance transactions, with a corresponding charge or credit to income. The Company recorded an adjustment to increase its deferred gain related to retroactive reinsurance coverage by $2,996,000, $3,662,000 and $4,615,000 in 2001, 2000 and 1999, respectively. For the years ended December 31, 2001, 2000 and 1999, the Company amortized deferred gains of $2,696,000, $5,199,000 and $3,850,000, respectively. Such amortization is included as a credit to specialty product expense on the accompanying consolidated statements of operations.

In accordance with SFAS No. 113, losses ceded under prospective reinsurance reduce direct incurred losses and amounts recoverable are reported as an asset. At December 31, 2001 and 2000, the amount of reinsurance recoverable under

prospective reinsurance contracts for unpaid loss and LAE was $187,453,000 and $218,757,000, respectively. At December 31, 2001 and 2000, the amount of reinsurance recoverable under the retroactive reinsurance contract was $8,781,000 and $10,863,000, respectively. The amount of reinsurance receivable for paid loss and LAE was $21,845,000 and $17,585,000 at December 31, 2001 and 2000, respectively.

Reinsurance contracts do not relieve the Company from its obligations to enrollees or policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company. The Company evaluates the financial condition of its reinsurers to minimize its exposure to significant losses from reinsurer insolvencies.

All of the reinsurance recoverables are due from reinsurers rated AA and A+ by Fitch Ratings and the A.M. Best Company, respectively, and all amounts are considered to be collectible.

The following table provides workers' compensation prospective reinsurance information for the three years ended December 31, 2001:

	Recoveries on Paid Losses/LAE	Change in Recoverable on Unpaid Losses/LAE
(In thousands)		
Year Ended December 31, 2001:		
Low level reinsurance carrier.....	$80,932	$(40,430)
Excess of loss reinsurance carriers.....	4,407	9,125
Total	$85,339	$(31,305)
Year Ended December 31, 2000:		
Low level reinsurance carrier.....	$53,408	$100,240
Excess of loss reinsurance carriers.....	2,324	8,428
Total	$55,732	$108,668
Year Ended December 31, 1999:		
Low level reinsurance carrier.....	$21,941	$ 69,104
Excess of loss reinsurance carriers.....	1,730	3,188
Total	$23,671	$ 72,292

7. LOSSES AND LOSS ADJUSTMENT EXPENSES

The following table provides a reconciliation of the beginning and ending reserve balances for workers' compensation unpaid losses and LAE. The loss estimates are subject to change in subsequent accounting periods and any change to the current reserve estimates would be accounted for in future results of operations in the period when the change occurs.

While management of the Company believes that current estimates are reasonable, significant adverse or favorable loss development could occur in the future.

Year ended Dece

(In thousands)	2001	2000
Net Beginning Losses and LAE Reserve	$155,797	$134,305
Net Provision for Insured Events Incurred in:		
Current Year	131,923	86,587
Prior Years	8,691	23,293
Total Net Provision	140,614	109,880
Net Payments for Losses and LAE Attributable to Insured Events Incurred in:		
Current Year	28,560	26,867
Prior Years	69,599	61,521
Total Net Payments	98,159	88,388
Net Ending Losses and LAE Reserve	198,252	155,797
Reinsurance Recoverable	187,453	218,757
Gross Ending Losses and LAE Reserve	$385,705	$374,554

During the years ended December 31, 2001 and 2000, the Company experienced prior year net adverse loss development of $8.7 million and $23.3 million, respectively. Estimated losses and LAE incurred in accident years 1996 to 1999 have developed significantly primarily due to the continuation of increasing claim severity patterns on the Company's California book of business. Many workers' compensation insurance carriers in California are also experiencing high claim severity. Factors influencing the higher claim severity include rising average temporary disability costs, the increase in the number of major permanent disability claims, medical inflation and adverse court decisions related to medical control of a claimant's treatment. See Note 6 for a description of our reinsurance coverage.

For the year ended December 31, 1999, the Company recorded net adverse loss development on prior accident years of $9.9 million, primarily for accident years 1996 to 1998.

8. LONG-TERM DEBT

Long-term debt at December 31, consists of the following:

(In thousands)	2001
Revolving Credit Facility	$ 89,000
Net Financing Obligations	73,948
7 1/2% Convertible Subordinated Debentures	
9 1/2% Senior Debentures	19,187
Other	1,236
Total	183,371
Less Current Portion	(1,612)

Long-term Debt	$181,759

Revolving Credit Facility. On October 31, 1998, the Company replaced its prior line of credit with a $200 million credit facility. As a result of the asset impairment and other changes in estimate charges, the Company was not in compliance with its financial covenants at June 30, 2000. On December 15, 2000, the Company entered into an amended and restated credit agreement, which terminates on September 30, 2003. The Company believes it is now in compliance with all covenants of the amended agreement. The restated agreement was subsequently amended in April 2001 to allow for the completion of the CII debenture exchange offer and again in October 2001 to provide a limited waiver for covenants affected by exiting the Texas HMO health care market.

The maximum availability under the amended and restated credit agreement has been reduced to $117 million at December 31, 2001 from $135 million at the end of 2000 due to required reductions in the agreement. At December 31, 2001, the Company has $28 million available under the agreement; however, the total availability will be reduced by $6.0 million on June 30, 2002 and December 31, 2002 and finally by $10.0 million on June 30, 2003. The amount available under the credit facility can be further reduced by 80% of net proceeds from certain asset sales and excess cash flow, as well as 100% of the net proceeds of any new debt or equity issuance, excluding any issuance by CII, as defined in the amended and restated credit agreement.

Subject to normal qualifications and exceptions, Sierra has covenants that, among other things, restrict its ability to dispose of assets, incur indebtedness, pay dividends, make investments, loans or advances, make acquisitions, engage in mergers or consolidations, or make capital expenditures and which otherwise restrict certain corporate activities. Any availability under the credit facility generated from excess cash flow must be converted annually to permanent reductions in accordance with the terms of the credit facility.

The amended and restated credit agreement restricts the amount of funds that can be invested in the Texas and SMHS operations. The maximum we can invest in the Military operations is $5 million, we have not invested any of the $5 million as of December 31, 2001. After September 30, 2001, we can invest an additional $5.0 million in the Texas operations and replace the Texas real estate assets with cash and notes up to $46 million. Under the terms of the amended and restated agreement, the use of Sierra funds to pay the outstanding Texas mortgage note of $29.2 million is not considered an investment in the Texas operations. During the fourth quarter of 2001, we invested in Texas the full $5.0 million allowed under the amended and restated agreement. If we had to invest more than we are allowed, we would be required to get a waiver or an amendment to our agreement or be out of compliance. If additional funds are needed by our discontinued Texas HMO health care operations and we do not transfer such funds they may be in violation of certain insurance regulations and we may be required to get a waiver or an amendment to our agreement or be out of compliance. There is no assurance that if we needed a bank waiver or amendment that we would be able to obtain it. Based on the current estimated Texas HMO healthcare run-out costs and recorded reserves, we believe we have adequate funds available and the ability to invest adequate funds in Texas to meet the anticipated obligations.

We are not allowed to pay or declare any cash dividends on our common stock under the terms of our amended and restated credit agreement. We have not paid or declared any cash dividends since inception. We anticipate that future earnings will be retained for our current operations; therefore, we do not plan to pay or declare any dividends on our common stock in the foreseeable future.

Interest under the amended and restated credit agreement is variable and based

on the Bank of America "prime rate" adjusted for a margin. The rate was 5.375% at December 31, 2001, which is a combination of the prime rate of 4.75% plus a margin of .625%. The Company can reduce the margin in the future by completing certain transactions and meeting certain financial ratios. Of the outstanding balance, $25 million is covered by an interest-rate swap agreement. To mitigate the risk of interest rate fluctuation on the credit facility, the Company entered into a five-year $50 million interest-rate swap agreement during the fourth quarter of 1998. The intent of the agreement was to keep the Company's interest rate on $50 million of the borrowing relatively fixed. In the fourth quarter of 2000, $25 million of the swap agreement was terminated. The interest rate swap is a derivative as described in SFAS No.133 and the Company recorded a liability for the interest-rate swap agreement at its fair market value of $685,000 as of December 31, 2001. Previously, the fair value of the asset or liability related to the swap was immaterial. The fair market value is the cost that the Company would need to pay to terminate the swap agreement as of December 31, 2001.

The average cost of borrowing on the credit facility for 2001, including the amortization of deferred financing fees and the impact of the swap agreement, was 10.6%. The terms of the amended and restated credit agreement contain certain covenants including a minimum fixed charge coverage ratio, a minimum interest coverage ratio, a maximum leverage ratio, maximum loss ratios and maximum capital expenditure amounts. The Company believes it is in compliance with these covenants at December 31, 2001.

Net Financing Obligations represent amounts recorded as a financing obligation of $90.8 million offset by notes receivable of $16.9 million as part of the sale-leaseback transaction described in Note 4. Amounts were recorded as a financing obligation as required by SFAS No. 98 using the interest method with effective interest rates of 8.16% to 8.53%. The balance outstanding under the net financing obligations was reduced by $14.6 million as described in Note 4 and by $2.7 million from the principal portion of the lease payments made during 2001.

Debentures. At September 30, 2000, CII Financial, Inc. had approximately $47.1 million of subordinated debentures outstanding that were due on September 15, 2001. These subordinated debentures were neither assumed nor guaranteed by Sierra and were subordinated to Sierra's credit facility debt. In December 2000, CII Financial commenced an offer to exchange the subordinated debentures for cash and/or new debentures. On May 7, 2001, CII Financial closed its exchange offer on $42.1 million of its outstanding subordinated debentures. CII Financial purchased $27.1 million in principal amount of subordinated debentures for $20.0 million in cash and issued $15.0 million in new 9 1/2% senior debentures, due September 15, 2004, in exchange for $15.0 million in subordinated debentures. The remaining $5.0 million in subordinated debentures were paid at maturity.

The transaction was accounted for as a restructuring of debt; therefore all future cash payments, including interest, related to the debentures will be reductions of the carrying amount of the debentures and no future interest expense will be recognized. Accordingly, the new 9 1/2% senior debentures have a carrying amount of $19.2 million, which consists of principal amount of $15.0 million and $4.2 million in future accrued interest.

The new 9 1/2% senior debentures pay interest, which is due semi-annually on March 15 and September 15 of each year, commencing on September 15, 2001. The new 9 1/2% senior debentures rank senior to outstanding notes payable from CII Financial to Sierra and CII Financial's guarantee of Sierra's revolving credit facility. The new 9 1/2% senior debentures may be redeemed by CII Financial at any time at premiums starting at 110% and declining to 100% for redemptions after April 1, 2004. In the event of a change in control of CII Financial, the holders of the new 9 1/2% senior debentures may require that CII Financial repurchase them at the then applicable redemption price, plus accrued and unpaid

interest.

Other. The Company has obligations under capital leases with interest rates from 8.0% to 12.2%. In addition, the Company has term loans with the City of Baltimore and the State of Maryland. Scheduled maturities of the Company's notes payable, net financing obligations and future minimum payments under capital leases, together with the present value of the net minimum lease payments at December 31, 2001, are as follows:

(In thousands) Years ending December 31,	Notes Payable	Obl Unde L
2002	$ 1,533	
2003	92,171	
2004	21,304	
2005	4,011	
2006	4,526	
Thereafter	59,437	
Total	$182,982	
Less: Amounts Representing Interest		
Present Value of Minimum Lease Payments		

The fair value of long-term debt, including the current portion, is estimated to be approximately $192,392,000 based on the borrowing rates currently available to the Company.

9. INCOME TAXES

A summary of the provision for income taxes for the years ended December 31, is as follows:

(In thousands)	2001	2000
Provision (Benefit) for Income Taxes:		
Current	$(1,131)	$ (795)
Deferred	9,934	(12,080)
Total	$ 8,803	$(12,875)

The following reconciles the difference between the reported and statutory provision (benefit) for income taxes, including discontinued operations, for the years ended December 31:

	2001	2000
Statutory Rate	35%	(35)%
State Income Taxes	(1)	1
Tax Preferred Investments	(2)	(1)
Change in Valuation Allowance	-	-
Intangible Amortization	1	11
Other	1	(1)

Provision (Benefit) for Income Taxes.....	34%	(25)%

The tax effects of significant items comprising the Company's net deferred tax assets are as follows at December 31:

(In thousands)	2001
Deferred Tax Assets:	
Medical and Losses and LAE Reserves.....	$ 10,506
Accruals Not Currently Deductible.....	16,542
Compensation Accruals.....	9,974
Bad Debt Allowances.....	4,061
Loss Carryforwards and Credits.....	59,756
Depreciation and Amortization.....	5,038
Unearned Premiums.....	1,757
Deferred Reinsurance Gains.....	2,022
Unrealized Investment Losses.....	3,033
Other.....	216
Total.....	112,905
Deferred Tax Liabilities:	
Deferred Policy Acquisition Costs.....	741
Other.....	947
Total.....	1,688
Net Deferred Tax Asset.....	$111,217

At December 31, 2001, the Company had approximately $154,942,000 of regular tax net operating loss carryforwards. The net operating loss carryforwards can be used to reduce future taxable income until they expire through the year 2020. In addition to the net operating loss carryforwards, the Company has alternative minimum tax credits of approximately $4,258,000, which can be used to reduce regular tax liabilities in future years. There is no expiration date for the alternative minimum tax credits.

The Company does not have a valuation allowance at December 31, 2001 or 2000. Included in other current receivables in the December 31, 2001 and 2000 balance sheets are income tax receivables of $2,265,000 and $1,326,000, respectively.

10. DISCONTINUED OPERATIONS

Throughout 2001, the Company continued to focus on making the Texas HMO health care operations profitable. Significant premium rate increases were made on renewing membership and during the third quarter the Company embarked on a recontracting effort to reduce medical costs. It was during this recontracting effort that unsustainable cost increases were identified, including the fact that the operations' primary hospital contract, if renewed, would be at a substantially higher rate than was previously indicated by the hospital.

Although considerable efforts had been made to achieve profitability in Texas, it was determined that under the current operating environment, the Company

would not be able to turn around the operating results and the best course of action was to exit the market as soon as possible to limit future losses and exposure. During the third quarter of 2001, the Company announced its plan to exit the Texas HMO health care market and received formal approval from the Texas Department of Insurance to withdraw its HMO operations in mid-October. The Company intends to cease providing HMO health care coverage in Texas on April 17, 2002.

The Company has elected to early adopt SFAS No. 144 effective January 1, 2001. In accordance with SFAS No. 144, the Company's Texas HMO health care operations have been reclassified as discontinued operations. The Company has received a limited waiver under its revolving credit facility agreement for covenants affected by exiting the Texas HMO health care market.

The following are condensed statements of operations of the discontinued Texas HMO health care operations:

(In thousands)	2001	Year Ended Dece 2000
Operating Revenues	$181,132	$ 233,39
Medical Expenses	175,333	233,65
General, Administrative and Marketing Expenses	29,607	31,34
Asset Impairment, Restructuring, Reorganization and Other Costs	(1,250)	186,60
Interest Expense and Other, Net	(1,532)	4,26
Loss from Discontinued Operations Before Tax	(21,026)	(222,47
Income Tax Benefit	7,046	61,35
Net Loss from Discontinued Operations	$(13,980)	$(161,12

All of the discontinued Texas HMO health care operations were a component of the "managed care and corporate operations" segment.

Based on the Company's Texas HMO health care operations financial projections for 2000, the Company recorded a $21.0 million premium deficiency at the end of 1999. Of this amount, $10.0 million was recorded in medical expenses and $11.0 million was recorded in asset impairment, restructuring, reorganization and other costs. The $11.0 million was an estimate of general and administrative costs, in excess of those covered by premiums, the Company expected to be incurred to service the Dallas/Ft. Worth contracts. Also recorded in medical expenses during the fourth quarter of 2000 was $4.0 million primarily related to an adjustment to the estimate for medical expenses recorded in previous years.

Included in the Texas HMO health care operations medical expenses for the year ended December 31, 2000 are $14.7 million, primarily for adverse development on prior periods' medical claims, and $15.5 million in premium deficiency medical expense related to under-performing markets in the Dallas/Ft. Worth and Houston areas. The recorded premium deficiency reflected anticipated costs after restructuring and reorganization actions taken in the first six months of 2000. During the second quarter of 2001, management revised their estimates of premium deficiency reserves and reclassified $7.8 million from premium deficiency maintenance reserve to premium deficiency medical reserve. This reclassification was based on the latest available medical cost trends, which did not become evident until late in the second quarter of 2001, and is reflected as an increase in medical expense and a decrease in general, administrative and

marketing expenses on the condensed statements of operations of the discontinued Texas HMO health care operations.

Asset impairment, restructuring, reorganization and other costs for the year ended December 31, 2000 include the following: (a) asset impairment charges of $126.4 million for impaired goodwill; (b) $36.5 million for impaired real estate and other fixed assets; (c) $10.4 million for premium deficiency maintenance costs; and (d) other restructuring, reorganization and other costs of $13.3 million.

As part of the Company's plan to exit Texas, the Company recorded charges of $10.6 million for premium deficiency medical costs, $1.6 million to write down certain Texas furniture and equipment, $2.0 million in lease and other termination costs, $1.8 million in legal and restitution costs, $500,000 in various other exit related costs and $570,000 in premium deficiency maintenance.

The table below presents a summary of discontinued Texas HMO health care operations' asset impairment, restructuring, reorganization and other cost activity for the periods indicated.

(In thousands)	Asset Impairment	Restructuring and Reorganization	Premium Deficiency Maintenance	Ot
Balance, January 1, 1999.....				
Charges recorded.....			$ 11,000	
Cash used.....				
Noncash activity.....				
Changes in estimate.....				
Balance, December 31, 1999.....	-	-	11,000	
Charges recorded.....	$ 162,937	$11,509	10,358	$1
Cash used.....		(7,754)	(12,080)	
Noncash activity.....	(162,937)			
Changes in estimate.....				
Balance, December 31, 2000.....	-	3,755	9,278	
Charges recorded.....	1,600	4,380	570	
Cash used.....		(3,716)	(1,478)	
Noncash activity.....	(1,600)	(125)		
Changes in estimate.....			(7,800)	
Balance, December 31, 2001.....	$ -	$ 4,294	$ 570	$

The remaining restructuring and reorganization costs of $4.3 million are primarily related to legal and restitution costs, lease and other termination costs, the cost to provide malpractice insurance on our discontinued affiliated medical groups and various other exit related costs. Management believes that the remaining reserves, as of December 31, 2001, are appropriate and that no revisions to the estimates are necessary at this time.

The following are the assets and liabilities of the discontinued Texas HMO health care operations:

(In thousands)	December 31 2001	D

ASSETS	
Cash and Cash Equivalents	$ 0
Accounts Receivable, Net	1,402
Other Assets	6,895
Property and Equipment, Net	20,107
TOTAL ASSETS	28,404
LIABILITIES	
Accounts Payable and Other Liabilities	16,407
Medical Claims Payable	36,567
Unearned Premium Revenue	68
Premium Deficiency Reserve	1,700
Mortgage Loan	29,189
TOTAL LIABLIITIES	83,931
NET LIABILITIES OF DISCONTINUED OPERATIONS	$(55,527)

Property and equipment consists mainly of real estate properties located in the Dallas/Fort Worth metroplex areas. TXHC acquired these properties from Kaiser Foundation Health Plan of Texas ("Kaiser-Texas"), for $44 million as part of the acquisition of certain assets of Kaiser-Texas in October 1998. In June 2000, as part of its restructuring and reorganization of the Texas HMO health care operations, the Company announced its intentions to sell these properties. The real estate was written down to its estimated fair value and the Company took an asset impairment charge of $27 million. The real estate is encumbered by a mortgage loan to Kaiser-Texas.

During 2001, Sierra participated in negotiations with Kaiser-Texas relative to the real estate properties and associated mortgage loan to Kaiser-Texas along with other matters. Sierra reached an agreement with Kaiser-Texas, effective December 31, 2001, whereby Kaiser-Texas forgave $8.5 million of the outstanding principal balance of the mortgage loan and extended the maturity from November 1, 2003 to November 1, 2006. In exchange for the consideration by Kaiser-Texas, Sierra agreed to an unconditional guaranty of the mortgage loan. In conjunction with the agreement, Sierra applied a $2.5 million outstanding receivable from Kaiser-Texas to the outstanding balance of the mortgage loan on December 31, 2001.

The agreement included concessions by Kaiser-Texas, including a reduction of principal and an extension of the maturity. In accordance with accounting principles generally accepted in the United States of America, the agreement was accounted for as a restructuring of debt. In the transaction, total future cash payments (interest and principal) were less than the balance of the mortgage loan at the time of the agreement. Accordingly, a gain on restructuring was recognized for the difference and the carrying amount of the mortgage loan is equal to the total future cash payments. Costs incurred in connection with the agreement were offset against the gain on restructuring. At December 31, 2001, the mortgage loan has a carrying value of $29.2 million, which consists of a principal balance of $22.7 million and $6.5 million in future accrued interest. Effective January 1, 2002, all future cash payments, including interest, related to the mortgage loan will be reductions of the carrying amount; therefore, no future interest expense will be recognized. The transaction resulted in an immaterial gain.

11. COMMITMENTS AND CONTINGENCIES

Leases. The Company is the lessee under several operating leases, most of which

relate to office facilities and equipment. The rentals on these leases are charged to expense over the lease term as the Company becomes obligated for payment and, where applicable, provide for rent escalations based on certain costs and price index factors. The following is a schedule, by year, of the future minimum lease payments under existing operating leases:

(In thousands) **Years Ending December 31,**	
2002	$ 8,805
2003	6,834
2004	5,851
2005	5,348
2006	4,551
Thereafter	26,965
Total	$58,354

Rent expense totaled $9,430,000, $8,788,000 and $7,725,000 for the years ended December 31, 2001, 2000 and 1999, respectively.

The Company is a guarantor on a mortgage loan which has a carrying value of $29.2 million, consisting of a principal balance of $22.7 million and $6.5 million in future accrued interest. The mortgage loan is related to the property of the discontinued operations as described in Note 10.

Litigation and Legal Matters. The Company is subject to various claims and other litigation in the ordinary course of business. Such litigation, for example, includes claims of medical malpractice, claims for coverage or payment for medical services rendered to HMO members and insureds and claims by providers for payment for medical services rendered to HMO members. Also included in such litigation are claims for workers' compensation and claims by providers for payment for medical services rendered to injured workers. In the opinion of the Company's management, the ultimate resolution of pending legal proceedings should not have a material adverse effect on the Company's operations or financial condition.

12. RELATED PARTY TRANSACTIONS

During 1997, the Company's Board of Directors authorized a $3.0 million loan from the Company to its Chief Executive Officer ("CEO"). In April 2000, the Company's Board of Directors authorized an additional $2.5 million loan from the Company to the CEO which, along with accrued interest, is due on June 30, 2002. During 2001, the CEO made payments of $898,000 and at the end of 2001, the aggregate principal balance outstanding and accrued interest for both instruments was $5.0 million. All amounts borrowed bear interest at a rate equal to the rate at which the Company could have borrowed funds under the revolving credit facility at the time of the borrowing plus 10 basis points. The amounts outstanding are collateralized by certain of the CEO's assets and rights to compensation from the Company.

The Company incurred legal fees of $38,000, $4,000 and $289,000 in the years ended December 31, 2001, 2000 and 1999, respectively, with a Nevada law firm of which a non-employee Board of Director member is a shareholder.

13. EMPLOYEE BENEFIT PLANS

Defined Contribution Plan. The Company has a defined contribution pension and

401(k) plan (the "Plan") for its employees. The Plan covers all employees who meet certain age and length of service requirements. For the six months ended June 30, 1999, the Company contributed a maximum of 2% of eligible employees' compensation and matched 50% of a participant's elective deferral up to a maximum of either 10% of an employee's compensation or the maximum allowable under current IRS regulations. Effective July 1, 1999, the Plan was modified such that the Company matches 50%-100% of an employee's elective deferral up to a maximum of 6% of a participant's annual compensation, subject to IRS limits. The Plan does not require additional Company contributions. Expense under the plan totaled $4.8 million, $4.7 million and $6.7 million for the years ended December 31, 2001, 2000 and 1999, respectively.

Supplemental Retirement Plans. The Company has Supplemental Retirement Plans (the "SRPs") for certain officers, directors and highly compensated employees. The SRPs are non-qualified deferred compensation plans through which participants may elect to postpone the receipt and taxation of all or a portion of their salary and bonuses received from the Company. Until July 1, 1999 the Company matched 50% of those contributions that participants are restricted from deferring, if any, under the Company's pension and 401(k) plan. As contracted with the Company, the participants or their designated beneficiaries may begin to receive benefits under the SRPs upon a participant's death, disability, retirement, termination of employment or certain other circumstances including financial hardship.

Executive Life Insurance Plan. The Company has split dollar life insurance agreements with certain officers and key executives (selected and approved by the Sierra Board of Directors). The premiums paid by the Company will be reimbursed upon the occurrence of certain events as specified in the contract.

Supplemental Executive Retirement Plan ("SERP"). The Company has a defined benefit retirement plan covering certain key employees. The Company is funding the benefits through the purchase of life insurance policies. Benefits are based on, among other things, the employee's average earnings over the five-year period prior to retirement or termination, and length of service. Benefits attributable to service prior to the adoption of the plan are amortized over the estimated remaining service period for those employees participating in the plan. During 2001, one participant began to receive benefits earlier than originally estimated. The effect of this change is included in actuarial losses (gains) in the reconciliation below.

A reconciliation of ending year balances is as follows:

	Years Ended	
	2001	20
(In thousands)		
Change in Benefit Obligation:		
Projected Benefit Obligation at Beginning of Period....	$13,693	$12
Service Cost	322	
Interest Cost	1,162	
Plan Amendments.....	335	
Actuarial Losses (Gains).....	4,410	
Benefits Paid	(784)	
Benefit Obligation at End of Period.....	$19,138	$13
Change in Plan Assets:		
Fair Value of Plan Assets at Beginning of Period.....	$ 8,439	$ 7
Actual Return on Plan Assets	(802)	

Company Contributions	2,678	1
Fair Value of Plan Assets at End of Period	$10,315	$ 8
Funded Status of the Plan	$(8,823)	$(5
Unrecognized Actuarial Change	3,399	
Unrecognized Prior Service Credit	7,062	7
Unrecognized Net Loss	4,117	2
Total Recognized	$ 5,755	$ 3
Total Recognized Amounts in the Financial Statements Consist of:		
Accrued Benefit Liability	$(6,134)	$(1
Intangible Asset	11,889	5
Total	$ 5,755	$ 3
Assumptions:		
Discount Rate	7.0%	7
Expected Return on Plan Assets	8.0%	8
Rate of Compensation Increase	3.0%	3
Components of Net Periodic Benefit Cost:		
Service Cost	$ 322	$
Interest Cost	1,162	
Expected Return on Plan Assets	(987)	
Amortization of Prior Service Credits	925	
Recognized Actuarial Loss (Gain)	159	
Net Periodic Benefit Cost	$ 1,581	$ 1

14. CAPITAL STOCK PLANS

Stockholders' Rights Plan. Each share of Sierra common stock, par value $.005 per share, contains one right (a "Right"). Each Right entitles the registered holder to purchase from Sierra a unit consisting of one one-hundredth (.001) of a share of the Sierra Series A Junior Participating Preferred Shares (a "Unit"), par value $.01 per share, or a combination of securities and assets of equivalent value, at a purchase price of $100.00 per Unit, subject to adjustment. The Rights have certain anti-takeover effects. The Rights will cause substantial dilution to a person or group that attempts to acquire Sierra on terms not approved by Sierra's Board of Directors, except pursuant to an offer conditioned on a substantial number of Rights being acquired. The Rights should not interfere with any merger or other business combination approved by the Board of Directors since Sierra may redeem the Rights at the price of $.02 per Right prior to the time that a person or group has acquired beneficial ownership of 20% or more of Sierra common stock.

Stock Option Plans. The Company has several plans that provide common stock-based awards to employees and to non-employee directors. The plans provide for the granting of options, stock, and other stock-based awards. Awards are granted by a committee appointed by the Board of Directors. Options become exercisable at such times and in such installments as set by the committee. The exercise price of each option equals the market price of the Company's stock on

the date of grant. Stock options generally vest at a rate of 20% - 33% per year. Options expire from one to seven years after the end of the vesting period.

The following table reflects the activity of the stock option plans:

	Number of Shares	Option Price
(Number of shares in thousands)		
Outstanding January 1, 1999	2,730	$ 6.31 - $24.83
Granted	1,436	6.69 - 21.00
Exercised	(2)	6.31 - 12.08
Canceled	(260)	11.71 - 24.83
Outstanding December 31, 1999	3,904	6.31 - 24.69
Granted	2,458	3.13 - 7.19
Canceled	(2,112)	3.75 - 24.69
Outstanding December 31, 2000	4,250	3.13 - 24.69
Granted	2,218	4.24 - 8.93
Exercised	(72)	3.75 - 8.00
Canceled	(393)	3.19 - 24.69
Outstanding December 31, 2001	6,003	3.13 - 24.69
Exercisable at December 31, 2001	1,391	3.13 - 24.69
Available for Grant at December 31, 2001	2,225	

The following table summarizes information about stock options outstanding at December 31, 2001:

(Number of options in thousands)

Range of Exercise Prices	Weighted Average Contractual Life Remaining in Days	Options Outstanding	Options Exercisable	Weigh Exer Outstandin
$ 3.13 - $ 5.73	3,215	3,635	576	$ 4.53
6.19 - 9.91	2,339	1,875	457	8.15
10.36 - 18.00	1,377	190	166	12.40
19.08 - 24.69	1,160	303	192	22.28

Employee Stock Purchase Plans. The Company has an employee stock purchase plan (the "Purchase Plan") whereby employees may purchase newly issued shares of common stock through payroll deductions at 85% of the fair market value of such shares on specified dates as defined in the Purchase Plan. During 2001, a total of 517,000 shares were purchased at prices of $2.92 and $3.60 per share. During January 2002, 203,000 shares were purchased by employees at $6.02 per share in connection with the Purchase Plan. At December 31, 2001, the Company had 531,000 shares reserved for purchase under the Purchase Plan.

Restricted Stock Units. The Company issued 244,000 restricted stock units ("units"), to certain executives during 2001. The first half of the units vest in 2003 with the remainder vesting in 2004. Each unit represents a nontransferable right to receive one share of Sierra stock and there is no cost by the recipient to exercise the units. The units are included in total outstanding common shares. In the calculation of earnings per share, the units are not included in the common shares outstanding but are included in the calculation of common shares outstanding assuming dilution. The transaction was recorded by including the value of the units as common stock and additional paid-in capital offset by a contra-equity account, deferred compensation. The value of the transaction was based on the number of units issued and the Company stock price on the date of issuance, which was $5.73. Compensation expense will be recognized over the period of vesting. Total expense associated with the plan for 2001 was $342,000.

Accounting for Stock-Based Compensation. The Company uses the intrinsic value method in accounting for its stock-based compensation plans. Accordingly, no compensation cost has been recognized for its employee stock option plans nor the Purchase Plan. Had compensation cost for the Company's stock-based compensation plans been determined based on the fair value at the grant dates for awards under those plans, the Company's net income and earnings per share for the years ended December 31, would have been reduced to the pro forma amounts indicated below:

		Years Ended Decem	
		2001	**2000**
(In thousands, except per share data)			
Net Income (Loss)	As reported	$3,486	$(199,915)
	Pro forma	(1,268)	(203,293)
Net Income (Loss) Per Share	As reported	$ .13	$ (7.37)
	Pro forma	(.05)	(7.49)
Net Income (Loss) Per Share Assuming Dilution	As reported	$ .12	$ (7.37)
	Pro forma	(.04)	(7.49)

The fair value of each option grant is estimated on the date of grant using the Black-Scholes option pricing model with the following weighted average assumptions used for grants in 2001, 2000 and 1999, respectively: dividend yield of 0% for all years; expected volatility of 83%, 52% and 43%; risk-free interest rates of 4.34%, 6.60% and 5.87%; and expected lives of three to five years. The weighted average fair value of options granted in 2001, 2000 and 1999 was $5.58, $2.72 and $3.77, respectively.

The fair value of the look-back option implicit in each offering of the Purchase Plans is estimated on the date of grant using the Black-Scholes option pricing model with the following weighted average assumptions used for grants in 2001, 2000 and 1999, respectively: dividend yield of 0% for all years; expected volatility of 85%, 46% and 45%; risk-free interest rates of 4.36%, 5.79% and 4.66%; and expected lives of six months for all years.

During 1999, the Company extended by three years the expiration date for 1,035,000 options covering shares that would have expired in 1999 and 2000. The exercise price per share for these options ranges from $10.92 to $20.50. No expense was recognized in the consolidated statement of operations related to these options. Expense of $1,445,000 is included in the Pro forma information presented.

Due to the fact that the Company's stock option programs vest over many years and additional awards are made each year, the above pro forma numbers are not

indicative of the financial impact had the disclosure provisions of Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation" been applicable to all years of previous option grants. The above numbers do not include the effect of options granted prior to 1995.

15. CONSOLIDATED STATEMENTS OF CASH FLOWS SUPPLEMENTAL INFORMATION

Supplemental statements of cash flows information is presented below:

	Years ended Dece	
	2001	**2000**
(In thousands)		
Cash Paid During the Year for Interest (Net of Amount Capitalized).....	$21,566	$26,848
Cash Received During the Year for Income Taxes.....	(221)	(10,608)
Non-cash Investing and Financing Activities:		
Retired Sale-Leaseback Assets, Liabilities and Financing Obligations.....	14,552	
Note Received for Sale of Investment.....		3,700
Stock Issued for Exercise of Options and Related Tax Benefits.....	97	
Additions to Capital Leases.....		1,835
Debentures Exchanged.....	19,692	

16. CERTAIN MEDICAL EXPENSES

During 1999, the Company reported a premium deficiency medical charge of $8.1 million related to losses in under-performing markets primarily in Arizona and rural Nevada, all of which was used during 1999. Also recorded in medical expenses during the fourth quarter was $7.2 million primarily related to an adjustment to the estimate for medical expenses recorded in previous years and $6.8 million primarily related to contractual settlements with providers of medical services.

In the first quarter of 2000, the Company recorded $1.0 million of adverse development related to prior years' medical claims. Included in reported medical expenses for the second quarter of 2000 are changes in estimate charges of $15.5 million of reserve strengthening primarily due to adverse development on prior periods' medical claims. In addition, the Company recorded $9.5 million of other non-recurring medical costs primarily relating to the write-down of medical subsidiary assets.

17. ASSET IMPAIRMENT, RESTRUCTURING, REORGANIZATION AND OTHER COSTS

Asset Impairments:

In the first quarter of 1999, the Company recorded a charge of $3.5 million related to the write-off of goodwill associated with the Mohave Valley operations. During the first quarter of 1999, the Company closed all inpatient operations at Mohave Valley Hospital, a 12-bed acute care facility in Bullhead City, Arizona, and terminated approximately 45 employees.

Management adopted a plan in the second quarter of 2000 to discontinue medical delivery operations in Mohave County, Arizona and to sell the real estate assets located there, as well as an underperforming medical clinic in Las Vegas.

In connection with the restructuring plans adopted and announced by the Company in the second quarter of 2000, the Company re-evaluated the recoverability of

certain long-lived assets, in accordance with SFAS No. 121 and APB No. 17 and determined that the carrying values of certain goodwill and other long-lived assets were impaired.

In assessing the asset impairment of the long-lived assets, the Company first allocated a portion of related goodwill to the fixed assets to be disposed of, in accordance with SFAS No. 121. The fixed assets were then written down to estimated fair value less costs to sell, which was determined from independent valuations. The remainder of the related goodwill was then assessed for recoverability in accordance with APB No. 17 based on projected discounted cash flows.

The charges recorded for the write-off of goodwill totaled $15.1 million and related primarily to the Prime Holdings, Inc. acquisition. The charges recorded for fixed asset impairment totaled $9.5 million for the Arizona and Nevada operations.

During the second quarter of 2000, the Company wrote-off capitalized costs of $3.0 million related to the application development of an information system software project for the workers' compensation operations, which was canceled because the vendor was unable to fulfill its contractual obligations. The amounts written off included software and consulting costs of $1.6 million and capitalized internal personnel costs of $1.4 million.

Restructuring and Reorganization:

In the first quarter of 1999, the Company incurred $450,000 for certain legal and contractual settlements and $400,000 to provide for the Company's portion of the write-off of start-up costs at the Company's equity investee, TriWest Healthcare Alliance.

In the second quarter of 2000, the Company adopted a plan and announced additional restructuring of the Arizona managed health care operations. As a result of this restructuring, the Company recorded charges in accordance with Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (Including Certain Costs Incurred in a Restructuring)" of approximately $2.0 million. Of the costs recorded, $1.2 million was for severance, $400,000 was related to clinic closures and lease termination and $400,000 was for other costs.

Other:

The $3.4 million of charges in the fourth quarter of 1999 consisted primarily of legal and contractual settlements.

The $4.3 million of costs recorded in the second quarter of 2000 relate primarily to the write-down of certain receivables as well as an accrual for legal settlements.

The table below presents a summary of asset impairment, restructuring and other costs for the years indicated.

(In thousands)	Asset Impairment	Restructuring and Reorganization	
Balance, January 1, 1999.....			$
Charges recorded.....	$ 3,509	$ 850	
Cash used.....		(850)	
Noncash activity.....	(3,509)		

Changes in estimate.....			
Balance, December 31, 1999.....	-	-	
Charges recorded.....	27,553	1,983	
Cash used.....		(1,389)	
Noncash activity.....	(27,553)		
Changes in estimate.....			
Balance, December 31, 2000.....	-	594	
Charges recorded.....			
Cash used.....		(594)	
Noncash activity.....			
Changes in estimate.....			
Balance, December 31, 2001.....	$ -	$ -	$

The remaining other costs of $4.4 million are primarily related to legal claims. Management believes that the remaining reserves as of December 31, 2001 are adequate and that no revisions to the estimates are necessary at this time.

18. UNAUDITED QUARTERLY INFORMATION

(In thousands, except per share data)

	March 31	June 30
Year Ended December 31, 2001 (1):		
Operating Revenues.....	$303,228	$318,327
Operating Income from Continuing Operations.....	10,062	11,391
Net Income from Continuing Operations.....	3,466	3,777
Net Income (Loss).....	3,205	2,795
Basic earnings per share:		
Income from Continuing Operations.....	$ 0.13	$ 0.14
Net Income (Loss).....	0.12	0.10
Diluted earnings per share:		
Income from Continuing Operations.....	$ 0.13	$ 0.13
Net Income (Loss).....	0.12	0.10
Year Ended December 31, 2000 (1):		
Operating Revenues.....	$265,591	$278,228
Operating Income (Loss) from Continuing Operations.....	11,263	(64,976)
Net Income (Loss) from Continuing operations.....	4,327	(50,484)
Net Income (Loss).....	1,556	(206,717)
Basic earnings per share:		
Income from Continuing Operations.....	$ 0.16	$ (1.87)
Net Income (Loss).....	0.06	(7.64)
Diluted earnings per share:		
Income from Continuing Operations.....	$ 0.16	$ (1.87)
Net Income (Loss).....	0.06	(7.64)

(1) The Company early adopted SFAS No. 144 effective January 1, 2001. All quarterly amounts have been reclassified to reflect the adoption of SFAS No. 144.

19. SEGMENT REPORTING

The Company has three reportable segments based on the products and services offered: managed care and corporate operations, military health services operations and workers' compensation operations. The managed care segment includes managed health care services provided through HMOs, managed indemnity plans, third-party administrative services programs for employer-funded health benefit plans, multi-specialty medical groups, other ancillary services and corporate operations. The military health services segment administers a five-year, managed care federal contract for the Department of Defense's TRICARE program in Region 1. The workers' compensation segment assumes workers' compensation claims risk in return for premium revenues and third party administrative services.

The Company evaluates each segment's performance based on segment operating profit. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies (except as described in the notes below). Certain changes in estimate charges for the years ended December 31, 2000 and 1999 have been reclassified to segment operation profit to conform with the current year presentation.

Information concerning the operations of the reportable segments is as follows:

(In thousands)

	Managed Care and Corporate Operations	Military Health Services Operations	Co
Year Ended December 31, 2001			
Medical Premiums	$718,994		
Military Contract Revenues		$338,918	
Specialty Product Revenues	7,875		
Professional Fees	28,985		
Investment and Other Revenues	2,790	2,404	
Total Revenue	$758,644	$341,322	
Segment Operating Profit (1)	$ 28,529	$ 9,701	
Interest Expense and Other	(16,758)	11	
Net Income from Continuing Operations Before Income Taxes	$ 11,771	$ 9,712	
Segment Assets	$401,686	$117,302	
Capital Expenditures	5,763	1,377	
Depreciation and Amortization	20,125	4,025	
Year Ended December 31, 2000			
Medical Premiums	$637,769		
Military Contract Revenues		$330,352	
Specialty Product Revenues	8,822		
Professional Fees	33,102		
Investment and Other Revenues	7,091	905	
Total Revenue	$686,784	$331,257	
Segment Operating Profit (1)	$ 24,514	$ 7,992	

Interest Expense and Other.....	(16,177)	(611)
Changes in Estimate Charges (2).....	(26,011)	
Asset Impairment, Restructuring, Reorganization and Other Costs.....	(30,836)	
Net (Loss) Income from Continuing Operations Before Income Taxes.....	$(48,510)	$ 7,381
Segment Assets.....	$479,786	$115,520
Capital Expenditures.....	13,957	717
Depreciation and Amortization.....	21,031	2,926
Year Ended December 31, 1999		
Medical Premiums.....	$594,966	
Military Contract Revenues.....		$287,398
Specialty Product Revenues.....	9,869	
Professional Fees.....	42,069	
Investment and Other Revenues.....	4,285	706
Total Revenue.....	$651,189	$288,104
Segment Operating Profit (1).....	$ 28,153	$ 11,612
Interest Expense and Other.....	(12,345)	(910)
Changes in Estimate Charges (2).....	(13,885)	
Asset Impairment, Restructuring, Reorganization and Other Costs.....	(7,808)	
Net (Loss) Income from Continuing Operations Before Income Taxes.....	$ (5,885)	$ 10,702
Segment Operating Assets.....	$446,379	$ 76,187
Capital Expenditures.....	44,858	570
Depreciation and Amortization.....	16,487	2,758

(1) The segment operating profit excludes the effects of asset impairment, restructuring, reorganization and other costs.

(2) Represents changes in estimate charges in the current year for services or liabilities of a prior year that are reclassified to either Medical Expenses or Specialty Product Expenses for presentation in accordance with accounting principles generally accepted in the United States of America.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information set forth under the caption "Election of Directors" in Sierra's Proxy Statement for its 2001 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information set forth under the caption "Compensation of Executive Officers" in Sierra's Proxy Statement for its 2001 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The information set forth under the caption "Security Ownership of Certain Beneficial Owners and Management" in Sierra's Proxy Statement for its 2001 Annual Meeting of Stockholders, is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The information set forth under the caption "Certain Relationships and Related Transactions" in Sierra's Proxy Statement for its 2001 Annual Meeting of Stockholders, is incorporated herein by reference.

PART IV

ITEM 14. EXHIBITS, FINANCIAL STATEMENT SCHEDULES AND REPORTS ON FORM 8-K

(a)(1) The following consolidated financial statements are included in Part II, Item 8 of this Report:

(a)(2) Financial Statement Schedules:

All other schedules are omitted because they are not applicable, not required, or because the required information is in the consolidated financial statements or notes thereto.

(a)(3) The following exhibits are filed as part of, or incorporated by reference into, this Report as required by Item 601 of Regulation S-K:

(3.1) Articles of Incorporation, together with amendments thereto to date, incorporated by reference to Exhibit 4 (b) to the Registrant's Registration Statement on Form S-8 (No. 33-41543) effective July 3, 1991.

(3.2) Certificate of Division of Shares into Smaller Denominations of the Registrant.

(3.3) Amended and Restated Bylaws of the Registrant, as amended through March 21, 2002.

(3.4) Certificant pursuant to NRS Section 78.207 increasing the number of authorized shares of common stock to 60,000,000 pursuant to the Company's stock split on May 18, 1998.

(4.1) Rights Agreement, dated as of June 14, 1994, between the Registrant and Continental Stock Transfer & Trust Company, incorporated by reference to Exhibit 3.4 to the Registrant's Registration Statement on Form S-3 effective October 11, 1994 (Reg. No. 33-83664).

(4.2) Rights Agreement, dated as of June 14, 1994, amended as of August 10, 2000, between the Registrant and Wells Fargo Bank Minnesota, N.A.

(4.3) Specimen Common Stock Certificate.

(10.1) Form of Contract With Eligible Medicare+Choice Organization and the Centers for Medicare and Medicaid Services for the period January 1, 2001 to December 31, 2001.

(10.2) Amended and Restated Credit Agreement dated as of December 15, 2000, among Sierra Health Services, Inc. as Borrower, Bank of America National Trust and Savings Association as Administrative Agent and Issuing Bank, First Union National Bank as Syndication Agent, and the Other Financial Institutions Party Thereto, incorporated by reference to Exhibit 1 to the Registrant's Current Report on Form 8-K filed December 22, 2000.

(10.3) Form of Indenture for 91/2% senior debentures due September 15, 2004 from CII Financial, Inc. to Wells Fargo Bank Minnesota, N.A., as Trustee, incorporated by reference to Exhibit 4.3 to CII Financial's Registration Statement on Form S-4 (File No. 333-52726)

(10.4) Specimen 91/2% senior debenture due September 15, 2004 of CII Financial (included in Exhibit 10.3 hereto)

(10.5) Compensatory Plans, Contracts and Arrangements.

(1) Employment Agreement with Jonathon W. Bunker dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(2) Employment Agreement with Frank E. Collins dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(3) Employment Agreement with William R. Godfrey dated December 10, 1999, incorporated by reference to Exhibit 10.8 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1999.

(4) Employment Agreement with Laurence S. Howard dated December 10, 1999 incorporated by reference to Exhibit 10.8 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1999.

(5) Employment Agreement with Anthony M. Marlon, M.D. dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(6) Employment Agreement with Erin E. MacDonald dated June 1, 2001, incorporated by reference to Exhibit 10.1 to Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2001.

(7) Employment Agreement with Michael A. Montalvo dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(8) Employment Agreement with Marie H. Soldo dated November 16, 2000, incorporated by reference to Exhibit 10.5 to Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(9) Employment Agreement with Paul H. Palmer dated December 1, 2001.

(10) Form of Split Dollar Life Insurance Agreement effective as of August 25, 1998, by and between Sierra Health Services, Inc., and Jonathon W. Bunker, Ria Marie Carlson, Frank E. Collins, William R. Godfrey, Laurence S. Howard, Erin E. MacDonald, Anthony M. Marlon, M.D., Kathleen M. Marlon, Michael A. Montalvo, John A. Nanson, M.D., Paul H. Palmer and Marie H. Soldo, incorporated by reference to Exhibit 10.5 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(11) Sierra Health Services, Inc. Deferred Compensation Plan effective May 1, 1996 as Amended and Restated Effective January 1, 2001, incorporated by reference to Exhibit 10.5 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(12) Sierra Health Services, Inc. Supplemental Executive Retirement Plan effective July 1, 1997, as Amended and Restated January 1, 2001, incorporated by reference to Exhibit 10.5 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(13) Sierra Health Services, Inc. Supplemental Executive Retirement Plan effective as of March 1, 1998, incorporated by reference to Exhibit 10 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 1998.

(14) The Registrant's Second Amended and Restated 1986 Stock Option Plan as amended to date, incorporated by reference to Exhibit 4 (a) to the Registrant's Registration Statement on Form S-8 (No. 33-41543) effective July 3, 1991.

(15) Amendment No. 1 to The Registrant's Second Amended and

Restated 1986 Stock Option Plan as amended to November 11, 1992.

(16) Amendment No. 2 to The Registrant's Second Amended and Restated 1986 Stock Option Plan as amended to March 16, 1993.

(17) Sierra Health Services, Inc. Management Incentive Compensation Plan incorporated by reference to Exhibit 10.8 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 1999.

(18) Sierra Health Services, Inc. 1995 Long-Term Incentive Plan, as amended and restated through December 11, 2001.

(19) Sierra Health Services, Inc. 1995 Non-Employee Directors' Stock Plan, as amended and restated through August 10, 2000, incorporated by reference to Exhibit 10.7 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2000.

(10.6) Loan Agreement dated August 11, 1997 between the Company and Anthony M. Marlon for a revolving credit facility in the maximum aggregate amount of $3,000,000, incorporated by reference to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 1997.

(10.7) Amendment No. 1 to Loan Agreement dated August 11, 1997 between the Company and Anthony M. Marlon for a revolving credit facility in the maximum aggregate amount of $3,000,000, incorporated by reference to Exhibit 10.8 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(10.8)Amendment No. 2 to Loan Agreement dated August 11, 1997 between the Company and Anthony M. Marlon for a revolving credit facility in the maximum aggregate amount of $3,000,000, incorporated by reference to Exhibit 10.9 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(10.9)Loan Agreement dated April 10, 2000 between the Company and Anthony M. Marlon for a term loan of $2,500,000, incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2000.

(10.10)Collateral Assignment of Rights dated April 10, 2000 between the Company and Anthony M. Marlon, incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2000.

(10.11)Purchase and Sale Agreement dated December 1, 2000 between Sierra Health Services, Inc., Health Plan of Nevada, Inc., Sierra Health and Life Insurance Company, Inc., 2716 North Tenaya Way Limited Partnership and CB Richard Ellis Corporate Partners, LLC and amendments one through seven thereof, incorporated by reference to Exhibit 10.16 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2000.

(10.12)Purchase and Sale Agreement dated December 1, 2000 between Sierra Health Services, Inc., Southwest Medical Associates, Inc., Health Plan of Nevada, Inc., 2314 West Charleston Partnership and CB Richard Ellis Corporate Partners, LLC and amendments one through seven thereof, incorporated by reference to Exhibit 10.17 to the Registrant's Annual

Report on Form 10-K for the fiscal year ended December 31, 2000.

(10.13) Settlement Agreement and Release of Claims between Kaiser Foundation Health Plan of Texas and Sierra Health Services, Inc. and certain subsidiaries.

(21) Subsidiaries of the Registrant (listed herein):

There is no parent of the Registrant. The following is a listing of the active subsidiaries of the Registrant:

Sierra Health and Life Insurance Company, Inc.
Health Plan of Nevada, Inc.
Sierra Health-Care Options, Inc.
Behavioral Healthcare Options, Inc.
Family Health Care Services
Family Home Hospice, Inc.
Southwest Medical Associates, Inc.
Sierra Medical Management, Inc. and Subsidiaries
Southwest Realty, Inc.
Sierra Health Holdings, Inc. (Texas Health Choice, L.C.)
CII Financial, Inc., and Subsidiaries
Northern Nevada Health Network, Inc.
Intermed, Inc.
Sierra Military Health Services, Inc.
Sierra Home Medical Products, Inc.
Nevada Administrators, Inc.

(23.1) Consent of Deloitte & Touche LLP

All other Exhibits are omitted because they are not applicable.

(b) Reports on Form 8-K

Current Report on Form 8-K, filed November 13, 2001, with the Securities and Exchange Commission in connection with the announcement of the Company's participation in a health care conference on November 14, 2001.

Current Report on Form 8-K, filed January 4, 2002, with the Securities and Exchange Commission in connection with the announcement of the Company's participation in a health care conference on January 8, 2002.

Current Report on Form 8-K, filed February 1, 2002, with the Securities and Exchange Commission in connection with the announcement of the Company's participation in a health care conference on February 5, 2002.

Current Report on Form 8-K, filed February 21, 2002, with the Securities and Exchange Commission in connection with the announcement of the Company's participation in a health care conference on February 27, 2002.

(d) Financial Statement Schedules

The Exhibits set forth in Item 14 (a)(2) are filed herewith.

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*The agreements contain certain schedules and exhibits which were not included in this filing. The Company will furnish supplementally a copy of any omitted schedule or exhibit to the Commission upon request.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has caused this report to be signed on its behalf by the undersigned thereto duly authorized.

SIERRA HEALTH SERVICES, INC.

By: /s/ Anthony M. Marlon, M.D.
Anthony M. Marlon, M.D.

Date: March 29, 2002

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Anthony M. Marlon, M.D. Anthony M. Marlon, M.D.	Chief Executive Officer and Chairman of the Board (Chief Executive Officer)	Marc
/s/ Paul H. Palmer Paul H. Palmer	Vice President of Finance, Chief Financial Officer, and Treasurer (Chief Accounting Officer)	Marc
/s/ Erin E. MacDonald Erin E. MacDonald	Director	Marc
/s/ Charles L. Ruthe Charles L. Ruthe	Director	Marc
/s/ William J. Raggio William J. Raggio	Director	Marc
/s/ Thomas Y. Hartley Thomas Y. Hartley	Director	Marc
/s/ Albert L. Greene	Director	Marc

Albert L. Greene

/s/ Michael E. Luce Michael E. Luce	Director	Marc
/s/ Anthony L. Watson Anthony L. Watson	Director	Marc

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT
CONDENSED BALANCE SHEETS - Parent Company Only
(In thousands)

	Dec 2001
CURRENT ASSETS:	
Cash and Cash Equivalents	
Short-term Investments	$ 1,585
Current Portion of Deferred Tax Asset	15,301
Prepaid Expenses and Other Current Assets	31,966
Total Current Assets	48,852
PROPERTY AND EQUIPMENT - NET	109,658
EQUITY IN NET ASSETS OF SUBSIDIARIES	50,582
NOTES RECEIVABLE FROM SUBSIDIARIES	9,345
GOODWILL	2,154
DEFERRED TAX ASSET	67,829
OTHER	27,532
TOTAL ASSETS	$315,952
CURRENT LIABILITIES:	
Accounts Payable and Other Accrued Liabilities	$ 22,836
Current Portion of Long-term Debt	3,728
Total Current Liabilities	26,564
LONG-TERM DEBT (Less Current Portion)	177,981
OTHER LIABILITIES	14,888
TOTAL LIABILITIES	219,433
STOCKHOLDERS' EQUITY:	
Capital Stock	148
Additional Paid-in Capital	181,076
Deferred Compensation	(1,058)
Treasury Stock	(22,789)
Accumulated Other Comprehensive Income	(5,636)
(Accumulated Deficit) Retained Earnings	(55,222)

Total Stockholders' Equity	96,519
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$315,952

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT (Continued)
CONDENSED STATEMENT OF OPERATIONS - Parent Company Only
(In thousands)

	Year Ended Decembe	
	2001	**2000**
OPERATING REVENUES:		
Management Fees	$ 69,603	$ 61,101
Subsidiary Dividends	10,000	5,137
Investment and Other Income	5,250	7,320
Total Operating Revenues	84,853	73,558
GENERAL AND ADMINISTRATIVE EXPENSES:		
Depreciation	14,125	10,650
Other	36,478	32,546
Asset Impairment, Restructuring, Reorganization and Other Costs		8,454
Total General and Administrative	50,603	51,650
INTEREST EXPENSE AND OTHER, NET	(9,065)	(15,945)
EQUITY IN UNDISTRIBUTED (LOSS) EARNINGS OF SUBSIDIARIES	15,456	(267,755)
INCOME (LOSS) BEFORE INCOME TAXES	40,641	(261,792)
BENEFIT (PROVISION) FOR INCOME TAXES	(37,155)	61,877
NET INCOME (LOSS)	$ 3,486	$(199,915)

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT (Continued)
CONDENSED STATEMENTS OF CASH FLOWS - Parent Company Only
(In thousands)

	2001

CASH FLOWS FROM OPERATING ACTIVITIES:	
Net Income (Loss)	$ 3,486
Adjustments to Reconcile Net Income (Loss) to Net Cash (Used for) Provided by Operating Activities:	
Depreciation and Amortization	14,231
Provision for Property Impairment	
Equity in Undistributed Earnings (Loss) of Subsidiaries	(15,456)
Change in Assets and Liabilities	(10,650)
Net Cash (Used for) Provided by Operating Activities	(8,389)
CASH FLOWS FROM INVESTING ACTIVITIES:	
Capital Expenditures	(3,915)
Property and Equipment Dispositions	5,356
(Increase) Decrease in Investments	(1,247)
Dividends from Subsidiaries	10,000
Acquisitions, Net of Cash Acquired	
(Decrease) Increase in Net Assets in Subsidiaries	39,772
Net Cash Provided by (Used for) Investing Activities	49,966
CASH FLOWS FROM FINANCING ACTIVITIES:	
Proceeds from Long-term Borrowing	7,500
Reductions in Long-term Obligations and Payments on Capital Leases	(49,926)
Notes Receivable from Subsidiaries	(16,910)
Purchase of Treasury Stock	
Exercise of Stock in Connection with Stock Plans	2,529
Net Cash (Used for) Provided by Financing Activities	(56,807)
Net (Decrease) Increase in Cash and Cash Equivalents	(15,230)
Cash and Cash Equivalents at Beginning of Year	15,230
Cash and Cash Equivalents at End of Year	$

Supplemental condensed statements of cash flows information:

Cash Paid During the Year for Interest (Net of Amount Capitalized)	$22,075
Cash Received During the Year for Income Taxes	(80)
Noncash Investing and Financing Activities:	
Stock Issued for Exercise of Options and Related Tax Benefits	97
Retired Sale-Leaseback Assets, Liabilities and Financing Obligations	14,552
Addition to capital leases	

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SCHEDULE I - CONDENSED FINANCIAL INFORMATION OF REGISTRANT (Continued)
NOTES TO CONDENSED INFORMATION OF REGISTRANT

For the Years Ended December 31, 2001 and 2000

1. LONG-TERM DEBT

Scheduled maturities of long-term debt, including the principal portion of obligations under capital leases, are as follows:

(In thousands) **Year Ending December 31,**	
2002	$ 3,728
2003	92,161
2004	11,059
2005	3,978
2006	4,492
Thereafter	66,291
Total	$181,709

2. OTHER

Reclassifications. Amounts related to our discontinued operations have been reclassified to conform with the current year presentation in the Condensed Financial Information of Registrant for the years ended December 31, 2000 and 1999.

Management Fees. Sierra Health Services, Inc. receives monthly management fees from certain wholly-owned subsidiaries for services performed. The majority of the fees are from Health Plan of Nevada, Inc. under an administrative services agreement that has been approved by the Nevada Division of Insurance. The fees have been recorded as reveneue in the Condensed Financial Information of Registrant for the three years ended December 31, 2001.

SIERRA HEALTH SERVICES, INC.
SUPPLEMENTAL INFORMATION
CONCERNING PROPERTY - CASUALTY INSURANCE
(In thousands)

Affiliation With Registrant Column A	Deferred Policy Acquisition Costs Column B	Gross Reserves for Unpaid Claims and Adjustment Expenses Column C	Discount if any Deducted in Column C Column D	Unearned Premiums Column E	Gross Earned Premiums Column F
Consolidated Property and Casualty Entities of CII Financial, Inc. for Years Ended:					

December 31, 2001.....	$2,236	$385,705	$0	$14,327	$186,296	
December 31, 2000.....	2,015	374,554	0	13,493	203,075	
December 31, 1999.....	2,378	244,394	0	13,300	146,682	

SIERRA HEALTH SERVICES, INC. AND SUBSIDIARIES
SECTION 403.04.b
EXHIBIT OF REDUNDANCIES (DEFICIENCIES)
(In thousands)

	Year ended December 3						
	2001	**2000**	**1999**	**1998**	**1997**	**1996**	**1995**
Losses and LAE Reserve.....	$385,705	$374,554	$244,394	$212,264	$202,699	$187,776	$182,318
Less Reinsurance Recoverables (1)	187,453	218,757	110,089	37,797	21,056	15,676	25,871
Net Loss and LAE Reserves.....	198,252	155,797	134,305	174,467	181,643	172,100	156,447
Net Reserve Re-estimated as of:							
1 Year Later ...		164,488	157,598	184,386	172,000	163,130	141,163
2 Years Later ..			171,136	204,029	173,596	146,987	132,193
3 Years Later ..				218,626	186,794	140,563	113,766
4 Years Later ..					198,403	146,266	102,652
5 Years Later ..						153,423	104,249
6 Years Later ..							108,208
7 Years Later ..							
8 Years Later ..							
9 Years Later ..							
10 Years Later..							
Cumulative Redundancy (Deficiency)....		(8,691)	(36,381)	(44,159)	(16,760)	18,677	48,239
Cumulative Net Paid as of:							
1 Year Later....		69,599	61,522	80,416	71,933	56,977	45,731
2 Years Later...			103,855	124,191	117,794	91,765	70,854
3 Years Later...				159,335	143,369	113,054	83,674
4 Years Later...					164,584	125,024	91,115
5 Years Later...						135,421	95,609
6 Years Later...							100,365
7 Years Later...							
8 Years Later...							
9 Years Later...							
10 Years Later..							
Net Reserve.....	198,252	155,797	134,305	174,467	181,643	172,100	156,447
Reins. Recoverables.	187,453	218,757	110,089	37,797	21,056	15,676	25,871
Gross Reserve	$385,705	374,554	244,394	212,264	202,699	187,776	182,318
Net Re-estimated Reserve		164,488	171,136	218,626	198,403	153,423	108,208
Re-estimated Reins.							

Recoverables ...	248,856	146,890	49,260	22,910	16,847	26,989
Gross Re-estimated Reserve	413,344	318,026	267,886	221,313	170,270	135,197
Gross Cumulative Redundancy (Deficiency)..	$(38,790)	$(73,632)	$(55,622)	$(18,614)	$ 17,506	$ 47,121

(1) Amounts reflect reinsurance recoverable under prospective reinsurance contracts only. The Company adopted Financial Accounting Standards Board Statement No. 113 ("FAS 113"), "Accounting and Reporting for Short-Duration and Long-Duration Reinsurance Contracts" for the year ended December 31, 1992. As permitted, prior financial statements have not been restated. Reinsurance recoverables on unpaid losses and LAE are shown as an asset on the balance sheets at December 31, 2001 and 2000. However, for purposes of the reconciliation and development tables, loss and LAE information are shown net of reinsurance.