Care1st Health Plan Arizona, Inc. and One Care by Care1st Health Plan Arizona, Inc.

Combined Financial Statements
As of and for the year ended December 31, 2016
and Independent Auditors' Report

Carelst Health Plan Arizona, Inc. and
One Care by Carelst Health Plan Arizona, Inc.

TABLE OF CONTENTS

Deloitte.

Deloitte & Touche LLP
Certified Public Accountants
Suite 3600
201 N Franklin Street
Tampa, FL 33602-5818
USA

Tel: +1 813 273 8300
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

The Audit Committee and Management
Care1st Health Plan Arizona, Inc. and
One Care by Care1st Health Plan Arizona, Inc.
Tampa, Florida

We have audited the accompanying combined financial statements of Care1st Health Plan Arizona, Inc. ("Care1st") and One Care by Care1st Health Plan Arizona, Inc. ("One Care") both of which are under common ownership and common management, together Care1st Arizona (the "Company"), are wholly owned subsidiaries of The WellCare Management Group, Inc. ("WCMG"), which comprise the combined balance sheet as of December 31, 2016, and the related combined statements of income, changes in stockholder's equity, and cash flows for the year then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements and supplemental schedules in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audit. We conducted our audit 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 combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also

includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

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

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of CareIst Arizona as of December 31, 2016, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information listed in the table of contents on page 19 are presented for the purpose of additional analysis and are not a required part of the financial statements. This supplementary information is the responsibility of the Company's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such information is fairly stated in all material respects in relation to the financial statements as a whole.

Deloitte & Touche LLP

May 5, 2017

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
BALANCE SHEET AS OF DECEMBER 31, 2016

ASSETS	As of December 31, 2016	
Current assets		
Cash and cash equivalents	$	121,574,000
ACA reimbursement receivable		8,991,000
Prepaid expenses and other		5,356,000
Total current assets		135,921,000
Restricted deposits		32,505,000
Deferred tax assets		732,000
Property and equipment, net		1,458,000
Total assets	$	170,616,000
LIABILITIES AND STOCKHOLDER'S EQUITY		
Current liabilities		
Medical claims payable	$	36,724,000
Accounts payable and accrued expenses		7,824,000
Other payables to government partners		60,649,000
Income tax payable		4,405,000
Total current liabilities		109,602,000
Additional paid-in capital		7,614,000
Retained earnings		53,400,000
Total stockholder's equity		61,014,000
Total liabilities and stockholder's equity	$	170,616,000

See notes to combined financial statements

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
STATEMENT OF INCOME FOR THE YEAR ENDED DECEMBER 31, 2016

	For the Year Ended December 31, 2016
Revenue	
Net premium revenue	$ 404,677,000
Interest income	224,000
Total revenue	404,901,000
Operating expenses	
Healthcare services, net	336,690,000
Selling, general and administrative expenses	35,371,000
Depreciation expense	625,000
Premium tax expense	7,510,000
ACA fee expense	6,076,000
Interest expense	42,000
Total expenses	386,314,000
Income before income taxes	18,587,000
Income tax expense	8,814,000
Net income	$ 9,773,000

See notes to combined financial statements

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
STATEMENT OF CHANGES IN STOCKHOLDER'S EQUITY FOR THE YEAR ENDED DECEMBER 31, 2016

	Common Stock Class A Number of Shares *	Additional Paid-In Capital	Retained Earnings	Total Stockholder's Equity
Balance, January 1, 2016	2,000	$ 7,614,000	$ 43,627,000	$ 51,241,000
Net income	-	-	9,773,000	9,773,000
Balance, December 31, 2016	2,000	$ 7,614,000	$ 53,400,000	$ 61,014,000

* *Includes 1,000 shares issued and authorized for Care1st Health Plan Arizona, Inc. and 1,000 shares issued and authorized for One Care by Care1st Health Plan Arizona, Inc.*

See notes to combined financial statement

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
STATEMENT OF CASH FLOWS FOR THE YEAR ENDED DECEMBER 31, 2016

	Year Ended December 31, 2016
Cash flows from operating activities	
Net income	$ 9,773,000
Adjustments to reconcile net income to cash provided by operating activities	
Depreciation expense	625,000
Deferred taxes, net	(77,000)
Other, net	(28,000)
Changes in operating accounts:	
ACA reimbursement receivable	(8,991,000)
Unearned premiums	(3,071,000)
Prepaid expenses, other assets and deposits	1,229,000
Payables to government partners	5,783,000
Accounts payable and accrued expenses	2,561,000
Medical claims payable and other medical liabilities	4,562,000
Income tax receivable/payable	(5,054,000)
Other, net	249,000
Net cash provided by operating activities	7,561,000
Cash flows from investing activities	
Purchase of property and equipment	(648,000)
Additions to restricted cash	(15,000,000)
Net cash used in investing activities	(15,648,000)
Cash flows from financing activities	
Contributions/distributions and dividends, net	-
Net cash provided by financing activities	-
Net change in cash and cash equivalents	(8,087,000)
Cash and cash equivalents, beginning of year	129,661,000
Cash and cash equivalents, end of year	$ 121,574,000
Supplemental disclosures of cash flow information:	
Cash paid for interest	$ 42,000
Cash paid for taxes	$ 11,250,000

See notes to combined financial statements

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONECARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
NOTES TO THE FINANCIAL STATEMENTS AS OF AND FOR THE YEAR ENDED DECEMEBER 31, 2016

NOTE 1 - ORGANIZATION AND BASIS OF PRESENTATION

Care1st Health Plan Arizona, Inc. ("Care1st") and One Care by Care1st Health Plan Arizona, Inc. ("One Care"), together Care1st Arizona (the "Company"), are wholly owned subsidiaries of The WellCare Management Group, Inc. ("WCMG"), which is a wholly-owned subsidiary of WCG Health Management, Inc., which, in turn, is a wholly-owned subsidiary of WellCare Health Plans, Inc. ("WellCare"), a publicly traded managed care services company that provides services exclusively to government sponsored health care programs. Care1st Arizona was acquired by WellCare on December 31, 2016 from Care1st Health Plan ("Care1st CA"), a subsidiary of California Physicians' Service dba Blue Shield of California. As of December 31, 2016, the Company provided benefits to approximately 117,000 Medicaid and 2,000 Medicare members.

Care1st was formed in October 2003 to provide specified health services to Medicaid members pursuant to a contract with the Arizona Health Care Cost Containment System ("AHCCCS"). Care1st also participates as an acute care subcontractor for the Arizona Department of Economic Security, Division of Developmental Disabilities program ("DDD"). Care1st subcontracts with hospitals, physicians and other medical providers within Arizona to care for eligible members in Maricopa County. In October 2013, the Arizona Plan's care for eligible AHCCCS members expanded to Pima County.

One Care was formed in March 2005 and commenced operations in October 2005 when the license by the Centers for Medicare and Medicaid Services ("CMS") was granted to One Care to provide services for the Medicare Advantage Prescription Drug Contracting ("MAPD") program. One Care provides health care services to enrollees in Maricopa County eligible for Medicare coverage including the Part D Prescription Drug Benefit. Coverage for members in Pima County began January 2014. One Care is contracted with CMS to provide managed care services as a Dual Eligible Subset Special Needs Plan (D-SNP). The contract limits One Care to only enroll members who are dually eligible for both Medicaid and Medicare.

Basis of Presentation

The Company's financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America ("GAAP"). We evaluated all material events subsequent to the date of these financial statements.

Principles of Consolidation

The accompanying combined financial statements of the Company have been prepared on a combined basis for entities under common control with all significant intercompany transactions and accounts being eliminated. The significant intercompany transactions and accounts of Care1st Health Plan Administrative Services, Inc. ("TPA"). a wholly-owned subsidiary of Care1st, have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in accordance with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires 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. The primary uses of estimates are related to the Company's reserve for claims unpaid. Actual results could differ significantly from those estimates.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Cash and Cash Equivalents

The Company considers all unrestricted highly liquid investments that are readily convertible to cash, with original maturity dates of three months or less when purchased, to be cash and cash equivalents. Cash and cash equivalents are stated at cost or amortized cost, which approximates fair value.

B. Restricted Deposits

As a condition for licensure, the Company is required to maintain certain funds on deposit or pledged to the state. The Company records these restricted regulatory deposits consisting of cash deposited with the Arizona State Treasurer at amortized cost, which approximates fair value. Due to the nature of the State's requirements, we classify restricted cash as long-term regardless of the contractual maturity date of the securities held. Refer to Note 5 for Regulatory Requirements.

C. Property and Equipment, net

Fixed Assets are stated at cost less accumulated depreciation. Major improvements that extend the useful lives of the assets are capitalized. Maintenance and repairs are charged to operating expense when incurred. When assets are retired or otherwise disposed of, the related cost and accumulated depreciation are removed from the books and any resulting gain or loss is recorded in the Statement of Income. Depreciation expense is computed using the straight-line method over the estimated useful lives of the related assets, which ranges from three to ten years.

	Estimated Useful Lives
Furniture and fixtures	5-10 years
Computer and office equipment	3-5 years
Leasehold improvements	Lesser of useful life or lease term

On an ongoing basis, the Company reviews events or changes in circumstances that may indicate that the carrying value of an asset may not be recoverable. If the carrying value of an asset exceeds the sum of estimated undiscounted future cash flows, then an impairment loss is recognized in the current period for the difference between estimated fair value and carrying value. If assets are determined to be recoverable, or the useful lives are shorter than originally estimated, the net book value of the assets is depreciated over the newly-determined remaining useful lives. There were no impairment losses recognized during the year ended December 31, 2016.

D. Fair Value

The carrying amounts of cash and cash equivalents, restricted cash, ACA reimbursement receivable, prepaid expenses and other current assets, accounts payable and accrued expenses, medical claims payable, and other payables to government partners at December 31, 2016, approximate fair value due to the relatively short-term nature of these instruments.

E. Recognition of Premium Revenue and Related Healthcare Services

Premium revenues are primarily derived from the Company's contracts with the State of Arizona and CMS. The premiums received are typically a fixed rate based on a membership category. The Company assumes the economic risk of funding its customers' health care and related administrative costs. Membership and category eligibility are periodically reconciled with the various programs and such reconciliations could result in adjustments to revenue. Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Premium billings may be subsequently adjusted to reflect changes in membership as a result of retroactive terminations, additions or other changes. Health care premium payments received in advance for a service period are recorded as unearned premiums. The Company recognizes revenue on retroactive healthcare premium adjustments that result in a benefit, generally when the amounts are determinable and collectability is reasonably assured in premium revenue.

Risk Adjusted Premiums

The Company's AHCCCS revenues are subject to risk adjustment. AHCCCS utilizes a national episodic/diagnostic risk adjustment model that is applied to prospective capitation payments.

Health Care Services

The Company arranges comprehensive healthcare services for its members generally through fee for service payments to providers. The Company also uses capitation, a fixed monthly payment made without regard to the frequency, extent or nature of the healthcare services actually furnished. All related expenses are included in health care services expense in the accompanying combined statement of income.

The Company maintains programs that provide incentives to participating providers through the use of various risk-sharing agreements. Payments are made to providers based on the risk-sharing agreements. Expenses related to the program are recorded as incurred based on contracted amounts.

Arizona AHCCCS Specific Revenue Recognition

Delivery supplemental payments are intended by AHCCCS to cover the costs of maternity care for deliveries during a prospective enrollment period. Such premiums are recognized in the month the delivery occurs.

Reinsurance revenues are recorded net of uncollectible amounts pursuant to the AHCCCS contract. Acute reinsurance revenue is recognized as a percentage of expenses incurred by members whose medical costs exceed a stated deductible per member per contract year. Catastrophic reinsurance revenue is recognized as the actual costs paid by the Arizona Plan. These revenues are included as an offset of other medical expenses. The Company recorded $9,700,000 of reinsurance revenues in medical expenses for the year ended December 31, 2016.

Prior period Coverage ("PPC") capitation premiums are payments received from AHCCCS for the period of time, prior to the member's enrollment, during which a member is eligible for covered services. Such premiums are recognized upon receipt.

F. ACA Reimbursement Receivable

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA"), imposed certain new taxes and fees, including an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers, which began in 2014. The Company received amendments, written agreements or other documentation from AHCCCS that commits the State to reimburse the Company for the portion of the ACA industry fee attributable to our Medicaid plans, including its non-deductibility for income tax purposes. Consequently, we recognized $8,991,000 of reimbursement for the ACA industry fee as premium revenue for the year ended December 31, 2016.

G. Claims Payable and Related Expenses

The Company recognizes the cost of medical benefits in the period in which services are provided, including an estimate of the cost of medical benefits incurred but not reported ("IBNR"). Medical benefits expense includes direct medical expenses and certain medically related administrative costs. The IBNR portion of medical claims payable is estimated based on past claims payment experience for member groups, enrollment data, utilization statistics, authorized healthcare services and other factors. Medical claims payable balances are continually monitored and reviewed. If it is determined that the Company's assumptions in estimating such liabilities are significantly different than actual results, the Company's combined results of operations and combined financial position could be impacted in future periods. Adjustments of prior period estimates may result in additional cost of care or a reduction of cost of care in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. As the liability is based upon estimates, the ultimate settlement of claims may be materially more or less than the amount included in the combined financial statements. While the ultimate amount of program expenses is dependent on future developments, the Company believes that the liability for claims payable is adequate to cover such expenses. Health care claims expenses are included in healthcare services expense in the accompanying combined statement of income.

H. Premium Deficiency Reserve

We evaluate our contracts to determine if it is probable that a loss will be incurred. We establish a premium deficiency reserve ("PDR") when it is probable that expected future healthcare services and administrative expenses will exceed future premiums and reinsurance recoveries for the remainder of a contract period. For purposes of determining a PDR, we do not consider investment income and contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. A PDR is recorded as healthcare services expense and in medical claims payable. Once established, a PDR is reduced over the contract period as an offset to actual losses. We re-evaluate our PDR estimates each reporting period and, if estimated future losses differ from those in the current PDR estimate, we adjust the liability through medical benefits expense, as necessary. We had no PDR liability recorded in our consolidated balance sheets as of December 31, 2016.

I. Other Payables to Government Partners

AHCCCS limits financial risk and gain to its contractors. Profits and losses by defined risk code groupings are annually reconciled as defined for each contract year ending in the month of September. In accordance with the reconciliations, profits and losses are generally limited to a defined percentage of the net capitation received for the specified risk code groupings. Profits or losses in excess of the corridor are reimbursed to, or recovered from, AHCCCS by the contractor. Accordingly, at December 31, 2016, the Company recorded a net payable of $60,649,000 in other payables to government partners. Generally, the final reconciliation and settlement is anticipated to take place approximately 15 months after the end of the contract year.

J. Concentrations of Credit Risk

The Company's operations are concentrated to the State of Arizona and CMS, which could cause the Company's revenues, profitability, or cash flow to change suddenly and unexpectedly as a result of significant premium rate reductions or payment delays, a loss of a material contract, legislative actions, changes in Medicaid or Medicare eligibility methodologies, or an unexpected increase in utilization in those states. For the year ended December 31, 2016 Medicaid and Medicare premium revenues as a percentage of gross revenue were 93 percent and 7 percent, respectively.

AHCCCS Agreement

On March 22, 2013 the Company was notified that the Arizona Plan received a contract award from AHCCCS Acute Care Program effective October 1, 2013. The contract term is for three years, with two one year options for renewal. Under the contract, the Arizona Plan will provide services to eligible enrollees in Maricopa and Pima Counties. The contract is currently extended through September 30, 2017.

K. Income Taxes

Deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis. Deferred tax assets and liabilities are measured using tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. A valuation allowance is recognized when, based on available evidence, it is more likely than not that the deferred tax asset may not be realized. The Company classifies interest and penalties associated with uncertain income tax positions as Income taxes within its financial statements.

L. Recently Adopted Accounting Standards

In January 2017, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2017-04, "*Intangibles—Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*". This update eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. As a result, an entity should perform its annual goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount and should recognize an impairment charge for the amount by which the carrying amount exceeds the reporting units' fair value; however, the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. We adopted this guidance prospectively on January 1, 2017. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows.

In October 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2016-17, "*Consolidation (Topic 810).*" This update changes how a reporting entity evaluates consolidation, including whether an entity is considered a variable interest entity, determination of the primary beneficiary and how related parties are considered in the analysis. We adopted this guidance effective January 1, 2017. The adoption of this guidance did not have a material effect on our combined results of operations, financial condition or cash flows.

In March 2016, the FASB issued ASU 2016-07, "*Simplifying the Transition to the Equity Method of Accounting,*" which eliminates the requirement to apply the equity method of accounting retrospectively when a reporting entity obtains significant influence over a previously held investment. Instead, the equity method of accounting should be applied prospectively from the date significant influence is obtained. Investors should add the cost of acquiring the additional interest in the investee (if any) to the current basis of their previously held interest. The new standard should

be applied prospectively for investments that qualify for the equity method of accounting after the effective date. We adopted this guidance effective January 1, 2017. The adoption of this guidance did not have a material effect on our combined results of operations, financial position or cash flows.

In November 2015, the FASB issued ASU 2015-17, "*Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes.*" ASU 2015-17 requires an entity to classify all deferred tax assets and liabilities as noncurrent. We adopted this standard effective January 1, 2016 and applied it retrospectively to all prior periods. These reclassifications did not affect results of operations or stockholders' equity, as previously reported.

In September 2015, the FASB issued ASU 2015-16, "*Business Combinations (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments.*" ASU 2015-16 eliminates the requirement for an acquirer to retrospectively adjust provisional amounts recorded in a business combination to reflect new information about the facts and circumstances that existed as of the acquisition date and that, if known, would have affected measurement or recognition of amounts initially recognized. The amendment requires that an acquirer recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. The amendments require that the acquirer record, in the financial statements of the period in which adjustments to provisional amounts are determined, the effect on earnings of changes in depreciation, amortization, or other income effects, if any, as a result of the change to the provisional amounts, calculated as if the accounting had been completed at the acquisition date. We adopted this standard effective January 1, 2016. The adoption of this guidance did not have a material effect on our combined results of operations, financial position or cash flows.

M. Recently Issued Accounting Standards

In April 2017, the FASB issued ASU No. 2017-08, "*Receivables—Nonrefundable Fees and Other Costs (Subtopic 310-20): Premium Amortization on Purchased Callable Debt Securities*". This update shortens the amortization period for the premium on certain purchased callable debt securities to the earliest call date. Currently, entities generally amortize the premium as a yield adjustment over the contractual life of the security. The new guidance does not change the accounting for purchased callable debt securities held at a discount. This guidance is effective for interim and annual periods beginning after December 15, 2018. Early adoption is permitted. We are currently assessing the effect this guidance will have on our consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, "*Business Combinations (Topic 805): Clarifying the Definition of a Business.*" The amendments in this Update provide guidance to assist entities with evaluating when a group of transferred assets and activities (collective referred to as a "set") is a business. This new guidance provides for a "screen", which requires a determination that when substantially all of the fair value of the gross assets acquired (or disposed of) is concentrated in a single identifiable asset or a group of similar identifiable assets, the set is not a business. If the screen's threshold is not met, a set cannot be considered a business unless it includes an input and a substantive process that together significantly contribute to the ability to create output, eliminating the evaluation of whether a market participant could replace missing elements. This guidance is effective for public entities for interim and annual periods beginning after December 15, 2017. Early adoption is permitted. We are currently assessing the effect this guidance will have on our combined financial statements.

In November 2016, the FASB issued ASU 2016-18, "*Statement of Cash Flows (Topic 230) Restricted Cash; a consensus of the FASB Emerging Issues Task Force.*" This update requires entities to reconcile, on the statement of cash flows, changes in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. This guidance is effective for public entities for interim and annual periods beginning after December 15, 2017, and will be applied retrospectively. Early adoption is permitted. We are currently assessing the effect this guidance will have on our combined financial statements.

In August 2016, the FASB issued ASU 2016-15, "*Statement of Cash Flows Classification of Certain Cash Receipts and Cash Payments (Topic 230).*" This update targets eight specific areas to clarify how these cash receipts and cash payments are presented and classified in the statement of cash flows. This guidance is effective for public entities for interim and annual periods beginning after December 15, 2017, with early adoption permitted. We do not believe this guidance will have a material effect on our combined financial statements.

In June 2016, the FASB issued ASU 2016-13, "*Financial Instruments – Credit Losses (Topic 326),*" which requires entities to use a current expected credit loss model, which is a new impairment model based on expected losses rather than incurred losses. Under this model, an entity would recognize an impairment allowance equal to its current estimate

of all contractual cash flows that the entity does not expect to collect from financial assets measured at amortized cost. The entity's estimate would consider relevant information about past events, current conditions, and reasonable and supportable forecasts, which will result in recognition of lifetime expected credit losses upon loan origination. ASU 2016-13 is effective for interim and annual reporting periods beginning after December 15, 2019, with early adoption permitted for annual reporting periods beginning after December 15, 2018. We are currently assessing the effect this guidance will have on our combined financial statements.

In February 2016, the FASB issued ASU 2016-02, "*Leases (Topic 842),*" which for operating leases, requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments in its balance sheet. This standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. This guidance is effective for public companies for fiscal years beginning after December 15, 2018, including interim periods within those fiscal years. Early adoption is permitted. We are currently assessing the effect this guidance will have on our combined financial statements.

In January 2016, the FASB issued ASU 2016-01, "*Financial Instrument - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities,*" which requires entities to measure equity securities that are not combined or accounted for under the equity method at fair value through net income. This amendment also simplifies the impairment test of equity investments without readily determinable fair values. This guidance is effective for public companies for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. Early adoption is permitted in certain circumstances. We are currently assessing the effect this guidance will have on our combined financial statements.

In May 2015, the FASB issued ASU 2015-09, "*Financial Services - Insurance (Topic 944): Disclosures about Short-Duration Contracts*", which addresses enhanced disclosure requirements for short-duration insurance contracts. The disclosures required by this update are aimed at providing users of financial statements with more transparent information about an insurance entity's initial claim estimates and subsequent adjustments to those estimates, methodologies and judgments in estimating claims, as well as the timing, frequency and severity of claims. Early adoption is permitted. We do not believe this guidance will have a material effect on our combined financial statements.

In May 2014, the FASB issued ASU 2014-09, "*Revenue from Contracts with Customers (Topic 606).*" ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. In August 2015, the FASB issued ASU 2015-14, "*Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*", which deferred the effective dates of ASU 2014-09 by one year. As such, the standard becomes effective for annual and interim reporting periods beginning after December 15, 2017. Given that substantially all of our revenues are derived from insurance contracts accounted for in accordance with ASC 944, Financial Services-Insurance, which are specifically excluded from the scope of ASU 2014-09, we do not anticipate this guidance will have a material effect on our consolidated results of operations, financial condition or cash flows.

We have reviewed all other recently issued accounting standards in order to determine their effects, if any, on the Company's results of operations, financial position and cash flows. Based on that review, management believes that none of these pronouncements are expected to have a significant effect on the Company's financial statements.

NOTE 3 - HEALTH CARE REFORM

In March 2010, the ACA became law and significantly reformed various aspects of the U.S. health insurance industry. Financing for these reforms comes in part from substantial additional fees and taxes on us and other health insurers, health plans and individuals, as well as reductions in certain levels of payments to us and other health plans under Medicare. The majority of regulations and interpretive guidance on provisions of the ACA have been issued by the Department of Health and Human Services, the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners. There may be provisions of the legislation that receive additional guidance and clarification in the form of regulations and interpretations.

The ACA included a number of changes that have affected the way plans operate, such as reduced Medicare premium rates, CMS Star Ratings, MLR and other provisions.

CMS Star Ratings

Certain provisions in the ACA provide additional Medicare revenue related to the achievement of higher Star Ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with Star Ratings of 4.0 or higher are eligible for year-round open enrollment, whereas plans with lower Star Ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS could exercise its authority to terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2017. As a result, plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings. One Care, which received a 2016 Star rating of 3.5, is eligible for year round open enrollment due to the nature of being a D-SNP plan.

CMS's current quality measurement methodology does not appropriately account for socio-economic determinants of health. Because we have a greater percentage of low-income members, we may be unable to achieve a 4.0 Star Rating for some or all of our plans without a legislative or regulatory adjustment to the quality measurement methodology. Though various regulatory and legislative solutions have been proposed, we continue to work with our legislative and regulatory partners to ensure this issue is adequately addressed.

Medical Loss Ratios

On May 6, 2016, CMS published regulations that overhauled Medicaid managed care requirements. These regulations include requirements that state Medicaid programs evaluate network adequacy standards; impose a requirement of managed care organizations ("MCO") to report medical loss ratios ("MLR") annually to states; and a requirement that states set MCO rates to reasonably achieve an MLR of greater than 85% as long as the capitation rates are actuarially sound. Additionally, these regulations expand federal financial participation reimbursement opportunities related to members with behavioral health issues who receive short term services in an alternative mental health institution and outline requirements for value-based provider contracting. Under the regulations, the states will also be tasked with developing and publicizing plan quality rating results. These changes will be phased in over the course of three years with some regulations being effective immediately on May 6, 2016.

Other Provisions

Beginning January 1, 2014, the Company is subject to an annual fee under section 9010 of the Affordable Care Act, payable on September 30 each year thereafter. This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, 2014. Beginning January 31, 2014 and each year thereafter, the estimate for the following year's fee is reclassified from unassigned surplus to special surplus monthly throughout the year. The Company paid and expensed $6,076,000 in 2016. On December 18, 2015, the President signed the Combined Appropriations Act of 2016 which, among other provisions, included a one-year moratorium on the ACA industry fee for 2017. Refer to Note 2 section F for discussion surrounding reimbursements received from the State.

Premiums related to our Medicaid contracts with AHCCCS are subject to an assessment or tax on Medicaid premiums. The premium revenues we receive from the states include the premium assessment. We have reported premium taxes on a gross basis, as premium revenue and as premium tax expense in the combined statements of income. We recognize the premium tax assessment as expense in the period we earn the related premium revenue and remit the taxes back to the state agencies on a periodic basis. We incurred Medicaid premium taxes of $7,510,000 for the year ended December 31, 2016.

NOTE 4 - PROPERTY AND EQUIPMENT, NET

Property and equipment, net consists of the following:

	As of December 31, 2016
Property and equipment	
Furniture and fixtures	909,000
Computer and office equipment	4,072,000
Leasehold improvements	386,000
	5,367,000
Accumulated depreciation	(3,909,000)
Property and equipment, net	1,458,000

The Company recognized depreciation expense of $625,000 for the year ended December 31, 2016

NOTE 5 – Regulatory Requirements

On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Company: Current Ratio of at least 1.0; Equity per Member of $170 for Contractors with enrollment less than 100,000 and $115 for Contractors with enrollment greater than 100,000; Medical Loss Ratio of at least 85%; and Administrative Cost Percentage no greater than 10%. The Company is in compliance with all four ratios for fiscal year 2016 and 2015. AHCCCS may elect to impose sanctions and penalties, the impact of which may be material to the combined financial statements if the plan does not meet these standards. However, as of December 31, 2016, no sanctions have been imposed against the Company.

As required by AHCCCS, the Company recorded as restricted cash regulatory deposits held by the Arizona State Treasurer's Office totaling $32,505,000 as a statutory deposit for the protection of the plan members (insolvency reserve).

NOTE 6 - FAIR VALUE MEASUREMENTS

The Balance Sheet includes certain financial instruments carried at amounts which approximate fair value, such as cash and cash equivalents, restricted cash and receivables. The carrying amount approximates fair value due to the short-term nature of these items. These financial assets are classified within Level 1 of the fair value hierarchy defined as quoted prices in active markets for identical assets or liabilities. The Company did not elect the fair value option for other assets or liabilities as of December 31, 2016.

NOTE 7 – CLAIMS PAYABLE

The following table provides a reconciliation of the beginning and ending balance of unpaid claims for the following periods:

	For the Year Ended December 31, 2016
Gross claims payable balance at January 1,	$ 32,162,000
Reinsurance Recoverable	(2,248,000)
Balance at January 1, net	$ 29,914,000
Amount incurred related to:	
Current year	340,230,000
Prior years	(3,740,000)
Total incurred	336,490,000
Amounts paid related to:	
Current year	(307,234,000)
Prior years	(26,105,000)
Total paid	(333,339,000)
Balance at December 31, net	$ 33,065,000
Reinsurance Recoverable at December 31,	$ 3,659,000
Gross claims payable balance at December 31,	$ 36,724,000

The estimated cost of incurred claims expense attributable to prior year dates of service decreased by $3,740,000 during 2016. Excluding the prior period development related to the release of the provision for moderately adverse conditions, medical benefits expense for the period ending December 31, 2016 was affected by approximately $2,312,000 of net favorable development related to prior years.

NOTE 8 - INCOME TAXES

The Company's operations for fiscal year 2016 were included in the combined federal tax return of Care1st Health Plan California as WCMG acquired the Company at the end of business on December 31, 2016. The following table provides the components of income tax expense:

	Year Ended December 31, 2016
Current	
Federal	$ 8,891,000
State	-
	8,891,000
Deferred	
Federal	(77,000)
State	-
	(77,000)
Income tax expense	$ 8,814,000

A reconciliation of income tax at the statutory federal rate of 35% to income tax at the effective rate is as follows:

	Year Ended December 31, 2016
Income tax benefit at statutory federal rate	$ 6,506,000
ACA insurer fee	2,127,000
Other, net	181,000
Total income tax expense	$ 8,814,000

Significant components of our deferred tax assets and liabilities are:

	Year Ended December 31, 2016
Deferred tax assets	
Employee benefits	$ 594,000
Reinsurane allowance	110,000
Other, net	255,000
Total deferred tax assets	959,000
Deferred tax liabilities	
Depreciation	(227,000)
Total deferred tax liabilies	(227,000)
Net deferred tax assets	$ 732,000

The Company's management believes that it is more likely than not that the Company will realize all of its future tax benefits, based on the weight of available evidence. As such, no valuation allowance was recorded in 2016.

NOTE 9 - RELATED PARTY TRANSACTIONS

The Company was acquired by WCMG on December 31, 2016 from Care1st CA. The Company has $1,526,000 due to Care1st CA included in accrued expenses and other payables as of December 31, 2016. The amounts due to Care1st CA primarily relate to shared services and payments made on behalf of Care1st.

NOTE 10 – RETIRMENT PLAN

Through December 31, 2016, Care1st CA sponsored a 401(k) defined contribution retirement plan (the "Plan"), available to all employees meeting eligibility requirements. Employees' contributions are voluntary, with an annual maximum contribution of 20% of gross compensation, not to excess the IRS limit. The employer's matching contribution is based on the Safe Harbor requirements under the 401(k) defined contribution retirement plan. The employee has a choice of investing in various investment funds, subject to Internal Revenue Service limits. The Company incurred $450,000 in employer contribution expense for the years ended December 31, 2016.

NOTE 11 - COMMITMENTS AND CONTINGENCIES

The Company's ultimate Parent, WellCare Health Plans, Inc., remains contingently liable for certain potential obligations stemming from settlements to resolve previous government investigations and related litigation. Unless otherwise indicated, these matters do not directly involve the Company and management does not expect the matters to have a material impact on the Company's financial position.

AHCCCS Audit

AHCCCS periodically audits, among other things, the accuracy, timeliness and omission rates of encounters. Errors are subject to sanction. Additionally, the AHCCCS contract requires the plan to meet identified Minimum Performance Standards ("MPS") related to clinical quality measures. Should the Company fail to meet MPS, the Company could be sanctioned. The Company must submit a corrective action plan to AHCCCS with 30 days following notification of a deficiency. Based on the results of the corrective action plan, AHCCCS may waive the sanctions and penalties. Should AHCCCS not waive them, the impact of the penalties and sanctions could be material to the overall consolidated financial position of the Company. MPS results have not yet been issued by AHCCCS for the contract year ended September 30, 2016.

Other Lawsuits and Claims

Based on the nature of our business, we are subject to regulatory reviews or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance and benefits companies and their reviews focus on numerous facets of our business, including claims payment practices, provider contracting, competitive practices, commission payments, privacy issues and utilization management practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to our business practices. We continue to be subject to such reviews, which may result in additional fines and/or sanctions being imposed, premium refunds or additional changes in our business practices.

Separate and apart from the legal matters described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, protests and appeals related to Medicaid procurement awards, wage and hour claims and other employment claims, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages including claims for liquidated or punitive damages, which are not covered by insurance. We review relevant information with respect to these litigation matters and we update our estimates of reasonably possible losses and related disclosures. We accrue an estimate for contingent liabilities, including attorney's fees related to these matters, if a loss is probable and estimable. Currently, we do not expect that the resolution of any of these currently pending actions, either individually or in the aggregate, will differ materially from our current estimates or have a material adverse effect on our results of operations, financial condition and cash flows. However, the outcome of any legal actions cannot be predicted, and therefore, actual results may differ from those estimates.

Operating Leases

We recorded rental expense of $1,068,000 in selling general and administrative expense for the year ended December 31, 2016, related to our operating leases for office space and equipment. Future minimum lease payments under non-cancelable operating leases with initial or remaining lease terms in excess of one year at December 31, 2016 are as follows:

	Minimum Lease Payments
2017	1,069,000
2018	1,091,000
2019	284,000
Total	2,444,000

NOTE 12 - SUBSEQUENT EVENTS

The Company has evaluated subsequent events for potential recognition and/or disclosure through May 5, 2017, the date the financial statements are available to be issued.

On May 1, 2017, Care1st completed the acquisition of certain assets, including Arizona Medicaid membership and certain provider contracts, from Phoenix Health Plan. The transaction included the transfer of approximately 44,000 Medicaid members to Care1st.

On March 1, 2017, the Company executed two Surety Bond contracts to perform services related to the Company's health plan contracts with AHCCCS for both its Care1st and One Care entities. The Surety Bond executed by Care1st,

for the amount of $33,000,000, is effective for the period March 1, 2017 through December 31, 2017 and may be extended through September 30, 2018. The Surety Bond executed by One Care, for the amount of $2,500,000, is effective for the period of March 1, 2017 through December 31, 2017 and may be extended through December 31, 2018. As a result of executing the Surety Bond contracts, AHCCCS no longer required us to hold a restricted deposit with the State of Arizona. On April 7, 2017, the Company received the $32,500,000 which was previously held as a deposit with the State of Arizona.