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

Combined Financial Statements
as of and for the years ended December 31, 2018
and 2017, Supplemental Schedules as of and for
the years ended December 31, 2018 and 2017,
and Independent Auditors' Report

Care1st Health Plan Arizona, Inc. and

One Care by Care1st Health Plan Arizona, Inc.

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INDEPENDENT AUDITORS' REPORT

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

We have audited the accompanying combined financial statements of Care1st Health Plan Arizona, Inc. ("Care 1st") and One Care by Care1st Health Plans 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., which comprise the combined balance sheets as of December 31, 2018 and 2017, the related combined statements of income, changes in stockholder's equity, and cashflows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements and supplemental schedule 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 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 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 Care1st Arizona as of December 31, 2018 and 2017, and the results of its operations and

its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Combined Supplementary Information

Accounting principles generally accepted in the United States of America require that the disclosure of short-duration contracts included in Note 7 to the financial statements be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Financial Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Restriction on Use

Our report is intended solely for the information and use of the board of directors and the management of Care1st Arizona and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

April 5, 2019

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
COMBINED BALANCE SHEETS AS OF DECEMBER 31, 2018 AND 2017

(amounts in thousands)

ASSETS	2018	2017
Current assets		
Cash and cash equivalents	$ 185,748	$ 156,394
Income tax receivable	740	679
Premiums Receivable	7,195	1,017
Prepaid expenses and other	12,584	6,775
Total current assets	206,267	164,865
Restricted deposits	5	5
Other receivables from government partners	119	—
Due from affiliates	1,704	5,306
Deferred tax assets	567	125
Property and equipment, net	477	864
Goodwill	8,330	8,330
Other intangibles	3,486	4,157
Total assets	$ 220,955	$ 183,652
LIABILITIES AND STOCKHOLDER'S EQUITY		
Current liabilities		
Medical claims payable	$ 78,857	$ 43,877
Accounts payable and accrued expenses	12,470	16,556
Other payables to government partners	70,013	69,065
Income tax payable	900	—
Due to affiliates	4,840	10,143
Total current liabilities	167,080	139,641
Additional paid-in capital	12,614	12,614
Retained earnings	41,261	31,397
Total stockholder's equity	53,875	44,011
Total liabilities and stockholder's equity	$ 220,955	$ 183,652

See notes to combined financial statements

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
COMBINED STATEMENTS OF INCOME FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

(amounts in thousands)	2018	2017
Revenue		
Net premium revenue	$ 568,185	$ 454,488
Net investment income	2,650	855
Total revenue	570,835	455,343
Operating expenses		
Healthcare services, net	481,915	394,095
Selling, general and administrative expenses	52,663	39,200
Depreciation and amortization expense	1,057	931
Premium tax expense	10,737	8,422
ACA fee expense	8,925	—
Total expenses	555,297	442,648
Income before federal income taxes	15,538	12,695
Federal income tax expense	5,674	4,698
Net income	$ 9,864	$ 7,997

See notes to combined financial statements

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
COMBINED STATEMENTS OF CHANGES IN STOCKHOLDER'S EQUITY FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

(amounts in thousands excluding stock shares)	Common Stock Class A Number of Shares *	Additional Paid-In Capital	Retained Earnings	Total Stockholder's Equity
Balance, January 1, 2017	2,000	$ 7,614	$ 53,400	$ 61,014
Equity transfer	—	—	(30,000)	(30,000)
Contribution from parent	—	5,000	—	5,000
Net income	—	—	7,997	7,997
Balance, December 31, 2017	2,000	$ 12,614	$ 31,397	$ 44,011
Net income	—	—	9,864	9,864
Balance, December 31, 2018	2,000	$ 12,614	$ 41,261	$ 53,875

** 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.
COMBINED STATEMENTS OF CASH FLOWS FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

(amounts in thousands)

	2018	2017
Cash flows from operating activities		
Net income	$ 9,864	$ 7,997
Adjustments to reconcile net income to cash provided by operating activities		
Depreciation & amortization expense	1,057	931
Deferred taxes, net	(442)	607
Premium Receivable	(6,178)	8,819
Changes in operating accounts:		
Payables to government partners	829	8,416
Accounts payable and accrued expenses	(4,086)	8,733
Medical claims payable and other medical liabilities	34,980	7,153
Income taxes receivable (payable)	839	(5,085)
Other, net	(7,509)	2,679
Net cash provided by operating activities	29,354	40,250
Cash flows from investing activities		
Business Acquisition - Phoenix Health Plans	—	(12,930)
Additions to restricted cash	—	32,500
Net cash provided by investing activities	—	19,570
Cash flows from financing activities		
Contributions/equity transfers, net	—	(25,000)
Net cash used in financing and miscellaneous activities	—	(25,000)
Net change in cash and cash equivalents	29,354	34,820
Cash and cash equivalents, beginning of year	156,394	121,574
Cash and cash equivalents, end of year	$ 185,748	$ 156,394
Supplemental disclosures of cash flow information:		
Cash paid for taxes	$ 5,276	$ 4,771

See notes to combined financial statements

NOTE 1 - ORGANIZATION AND NATURE OF OPERATIONS

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 (doing business as Blue Shield of California). As of December 31, 2018 and 2017, the Company provided benefits to 186,119 and 152,686 Medicaid members, respectively. As of December 31, 2018 and 2017, the Company provided benefits to 1,770 and 2,097 Medicare members, respectively.

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. From October 2013 through September 2018, the Arizona Plan's care for eligible AHCCCS members included 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 Medicare Advantage ("MA") health plans and prescription drug benefits to Medicare beneficiaries through the Medicare Part D Program ("PDP"). Coverage for members in Pima County began January 2014 and ended December 2018. One Care is contracted with CMS to provide managed care services as a Dual Eligible Subset Special Needs Plan ("D-SNP"). One Care is limited to only enroll members who are dually eligible for both Medicaid and Medicare and in the service areas covered under the AHCCCS agreement.

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 42,000 Medicaid members to Care1st.

AHCCCS Agreement

On March 13, 2018 the Company announced that it received a contract award from the AHCCCS Complete Care program effective October 1, 2018. The contract term is for five years, with two one year options for renewal. Under the contract, the Arizona Plan will provide physical and behavioral health services to eligible enrollees in the Central and North geographic service areas.

NOTE 2 – BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

A. 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. Certain prior year amounts have been reclassified to conform to the current year's presentation.

B. Principles of Combination

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 combination.

C. 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.

D. Cash and Cash Equivalents

Cash represents amounts held by the Company in disbursement accounts at banks. Cash equivalents consist of short-term highly liquid investments with original maturities of three months or less. Cash equivalents are stated at cost or amortized cost, which approximates fair value.

E. Receivable from/Payable to Affiliates

Amounts receivable from or payable to affiliates resulting from inter-company arrangements are generally settled within 30 days and are non-interest bearing unless the payment is late.

F. Funds Receivable/Held for the Benefit of Members

The Company receives certain Part D prospective subsidy payments from CMS for MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in the bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and the Company based on the difference between the prospective payments and actual claims experience. The subsidy components under Part D are described below:

Low-Income Cost Sharing Subsidy ("LICS")-For qualifying low-income subsidy members, CMS reimburses the Company for all or a portion of the low income subsidy member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold.

Catastrophic Reinsurance Subsidy-CMS reimburses the Company for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy.

Coverage Gap Discount Subsidy ("CGDS")-CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members.

Catastrophic reinsurance subsidies and LICS subsidies represent cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Therefore, amounts received for these subsidies are not considered premium revenue, and are reported, net of the subsidy benefits paid, as deposits. Costs incurred over deposits received are recorded as assets and deposits received in excess of costs incurred are recorded as liabilities on the financial statements. Historically, the settlement payments between us and CMS has not been materially different from our estimates.

CGDS advance payments are recorded as assets on the financial statements. Receivables are set up for manufacturer invoiced amounts. Manufacturer payments reduce the receivable as payments are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGDS, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted Prescription Drug Event data.

G. Net Investment Income Earned

Net investment income earned but not yet collected is recorded as investment income due and accrued in the Balance Sheets. Investment income included in the accompanying Statements of Income is comprised of interest and dividends earned on the Company's invested assets, on cash and cash equivalents and net realized gains and losses on the sale of investments.

H. 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.

I. 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 years ended December 31, 2018 and 2017.

J. Other Receivables / 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, 2018 and 2017, the Company recorded a payable of $69,894 and $69,065, respectively, as a component of 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.

Medicaid Minimum Loss Ratio

The Company's Medicaid contract with AHCCCS includes a provision whereby the Company is required to expend a minimum of 85% of the premiums received related to on allowable medical benefits expense as defined in the contract (“Financial Visibility Standards - Acute Care”). The Company is also required to spend at most 10% of premiums received related to administrative expenses as defined in the same section of the contract.

For contract years 2017 and prior, AHCCCS will reconcile the Contractor’s Prospective, Prior Period Coverage (“PPC”) and Newly Eligible Adults (“NEAD”) medical cost expenses to Contractor’s Prospective, PPC and NEAD capitation paid to the Contractor during the year in accordance with ACOM policies 311, 302 and 316, respectively. These reconciliations will limit the Contractor’s profits to 4.5%, 2% and 1%, respectively, and losses to 3%, 2% and 1%, respectively. We are currently accruing paybacks of $1,544 for Contract Year Ending (“CYE”) 2015, $2,199 for CYE2016, $41,173 for CYE2017, which is recorded as a component of other payables to government partners on the balance sheet.

For contract year 2018, AHCCCS will reconcile NEAD medical expenses as part of the Prospective and PPC reconciliations, in accordance to the Actuarial Certification for the October 2017 to September 2018 rates. The CYE2018 reconciliations limit the Contractor’s profits to 4.5% for Prospective and 2% for PPC, and losses to 3% and 2%, respectively. We are currently accruing a refund of $24,952, which is recorded as a component of other payables to government partners on the balance sheet.

For CYE2019, there will be one reconciliation combining Prospective, PPC, and NEAD business. There is a 50% payback corridor between 2% and 6% profit, and all profit above 6% of net settlement revenue must be paid back, making a maximum possible gain of 4% of settlement revenue. Maximum losses are capped at 2%. We currently are accruing $145 and are very close to the 2% profit corridor.

Medicare Risk Corridor

At December 31, 2018 and 2017, there was a balance due from CMS of approximately $119 and $0, respectively, which is recorded as a component of other receivables from government partners.

Medicare Minimum Medical Loss Ratio

Beginning in 2014, the Patient Protection and Affordable Care Act, amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the “ACA”), established a minimum medical loss ratio (“MLR”) for MA and Part D prescription drug program (“Part D plans”), requiring plans to spend not less than 85% of premiums on medical and pharmacy benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan’s MA contract for prolonged failure to achieve the minimum MLR. The MLR is determined by adding a plan’s spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). No refund was due from or payable to CMS for this provision in 2018 or 2017.

K. Premium Deficiency Reserve

The Company’s contracts are evaluated to determine if it is probable that a loss will be incurred. A premium deficiency reserve ("PDR") is established when it is probable that expected claims payments or incurred costs, claims adjustment expenses, and general administration expenses will exceed future premiums and reinsurance recoveries for the remainder of a contract period. For purposes of determining a PDR, investment income is excluded and contracts are grouped in a manner consistent with the method of marketing, servicing and measuring the profitability of such contracts. A PDR is recorded as an aggregate health policy reserves and as an increase in medical expenses. Once established, a PDR is reduced over the contract period as an offset to actual losses. The PDR estimates are reevaluated each reporting period and, if estimated future losses differ from those in the current PDR estimate, the liability is adjusted through increase in medical expenses, as necessary. The Company had no PDR liability recorded within its liabilities as of December 31, 2018 and 2017.

L. Premium Revenue and Premiums Receivable

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.

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 $17,559 and $12,725 of reinsurance revenues in healthcare services, net for the years ended December 31, 2018 and 2017.

Prior period Coverage 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.

Value Based Purchasing
Care1st is subject to a recoupment by AHCCCS of 1% of eligible capitation revenue to fund the AHCCCS value based purchasing/alternative payment model initiatives. The purpose of these initiatives are to encourage activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings by aligning the incentives of the plan and its providers. Care1st can become eligible for a quality distribution by meeting the criteria established by AHCCCS for a measurement year. As of December 31, 2018 and 2017, Care1st accrued the 1% maximum liability.

Risk-Adjusted Premiums
CMS provides risk-adjusted payments for MA and PDP plans based on the demographics and health severity of enrollees. The risk-adjusted premiums received are based on claims and encounter data that are submitted to CMS within prescribed deadlines. The Company develops estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. The Company recognizes periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which is possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or when notification of such settlement amounts is received. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year. Historically, there have not been significant differences between estimates and amounts ultimately received. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur. An audit may result in the refund of premiums to CMS. While experience to date has not resulted in a material refund, future refunds could materially reduce net premium revenue in the year in which CMS determines a refund is required.

M. Medical Claims Payable and Loss Adjustment Expenses

The cost of medical benefits is recognized in the period in which services are provided, including an estimate of the cost of medical benefits incurred but not reported ("IBNR"). Medical benefits and unpaid claims expenses include direct medical expenses and certain medically-related administrative costs. Medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. The Company contracts with these providers on a fee-for-service or capitated basis. Capitation costs represent contractual monthly fees paid to participating providers on a per member per month basis, regardless of the medical services provided to members.

The Company also records direct medical expenses for estimated referral claims related to health care providers under contract with the Company who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by others. In these instances, the Company may be required to honor these obligations for legal or business reasons. Based on the current assessment of providers under contract with the Company, such losses have not been and are not expected to be significant. The Company records direct medical expense for estimates of provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences and amounts due to contracted providers under risk-sharing arrangements. The Company estimates pharmacy rebates earned based on historical utilization of specific pharmaceuticals, current utilization and record amounts as a reduction of recorded direct medical expenses.

Medical claims payable represent amounts for claims fully adjudicated but not yet paid and estimates for IBNR. The estimate of IBNR is the most significant estimate included in the Company's combined financial statements. The Company determines the best estimate of the base liability for IBNR utilizing consistent standard actuarial methodologies based upon key assumptions which vary by business segment. The assumptions include current payment experience, trend factors, and completion factors. Trend factors in standard actuarial methodologies include contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefit changes, expected health care cost inflation, seasonality patterns, maturity of lines of business, changes in membership and other factors.

After determining an estimate of the base liability for IBNR, the Company makes an additional estimate, also using standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than the estimated base reserve. This additional liability is referred to as the provision for moderately adverse conditions. The estimate of the provision for moderately adverse conditions captures the potential adverse development from factors such as:

- entry into new geographical markets;
- provision of services to new populations such as the aged, blind and disabled;
- variations in utilization of benefits and increasing medical costs, including higher drug costs;
- changes in provider reimbursement arrangements;
- variations in claims processing speed and patterns, claims payment and the severity of claims; and
- health epidemics or outbreaks of disease such as the flu or enterovirus.

The Company evaluates estimates of claims payable as it obtains more complete claims information and medical expense trend data over time. The Company records differences between actual experience and estimates used to establish the liability, which is referred to as favorable and unfavorable prior period developments, as increases or decreases to medical expense in the period the Company identifies the differences.

N. Member Acquisition Costs

We incur variable costs that relate to the acquisition of new and renewal health insurance business. Such costs include broker commissions, internal commissions, cost of policy issuance and underwriting, and other costs incurred to acquire new business or renew existing business. We record these costs as general administrative expenses in the combined Statements of Income as they are incurred.

O. Advertising Costs

We record the production costs of advertising activities as general administrative expenses when incurred. We expense the costs of communicating advertising campaigns in the period the advertising takes place. We recorded advertising and related marketing expense of $1,183 and $458 for the years ended December 31, 2018 and 2017, respectively.

P. Income Taxes

The Company is included in a consolidated federal income tax return with its ultimate parent, WellCare. 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 combined financial statements.

Q. Comprehensive Income

Comprehensive income includes all changes in stockholder's equity (except those arising from transactions with stockholders) and includes net income and net unrealized appreciation (depreciation), after tax, on investments available for-sale.

R. Recently Issued and Adopted Accounting Standards

Recently Adopted Accounting Standards
In February 2018, the FASB issued ASU 2018-02 "*Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income",* which allows entities to reclassify stranded tax effects resulting from the *Tax Cuts and Jobs Act of 2017* from accumulated other comprehensive income to retained earnings. The guidance is effective for interim and annual periods beginning after December 15, 2018, with early adoption permitted. We adopted this guidance prospectively on January 1, 2019. We do not anticipate the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

In January 2017, the Financial Accounting Standards Board 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 unit's 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, 2018. We do not anticipate the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

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 (collectively 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 prospective business combinations for public entities for interim and annual periods beginning after December 15, 2017. We adopted this guidance prospectively on January 1, 2018. We do not anticipate the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

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. We adopted this guidance on January 1, 2018. We do not anticipate the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

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 adopted this guidance on January

1, 2018. We do not anticipate the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

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. We adopted this guidance prospectively on January 1, 2018. We do not anticipate the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

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 the adoption of this guidance to have a material effect on our combined results of operations, financial condition or cash flows.

Recently Issued Accounting Standards

In August 2018, the FASB issued ASU 2018-15, "*Intangibles-Goodwill and Other-Internal-Use Software: Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract",* which requires implementation costs incurred by customers in cloud computing arrangements (i.e., hosting arrangements) to be capitalized under the same premises of authoritative guidance for internal-use software, and deferred over the noncancellable term of the cloud computing arrangements plus any option renewal periods that are reasonably certain to be exercised by the customer or for which the exercise is controlled by the service provider. The guidance is effective for interim and annual periods beginning after December 15, 2019. Early adoption is permitted. We are currently assessing the effect this guidance will have on our combined results of operations, financial condition or cash flows.

In March 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 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 do not expect the adoption of this guidance to have a material effect on our results of operations or cash flows. The effect of ASU 2016-02 on our combined financial position will be based on leases outstanding at the time of adoption.

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 combined financial statements.

S. Goodwill and Other Intangible Assets

Acquisitions typically result in goodwill, which represents the excess of the acquisition cost over the fair value of net assets acquired. Goodwill is assigned to reporting units, which we determined to be the same as our operating segments. Refer to Note 11 - Goodwill and Other Intangible Assets, Net for additional discussion.

We test goodwill for impairment at the reporting unit level at least annually, or more frequently if events or circumstances indicate that it would be more likely than not that the fair value of a reporting unit is below its carrying value. Such events or circumstances could include a significant adverse change in business climate, an adverse action or assessment by a regulator, unanticipated competition and the testing for recoverability of a significant asset group within a reporting unit, among others. To determine whether goodwill is impaired, we compare an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds the estimated fair value, we compare the implied fair value of the applicable goodwill to its carrying value to measure the amount of goodwill impairment, if any. We perform our annual goodwill impairment test based on our financial position and results of operations as of June 30 of each year, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting and planning process. The annual impairment tests are based on an evaluation of estimated future discounted cash flows. The estimated discounted cash flows are based on the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Our discounted cash flow estimates use discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our operating segments. Certain other key assumptions utilized, including changes in membership, premium, health care costs, operating expenses, fees, assessments and taxes and effective tax rates, are based on estimates consistent with those utilized in our annual budgeting and planning process that we believe are reasonable. However, if we do not achieve the results reflected in the assumptions and estimates, our goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment. Impairments, if any, would be classified as an operating expense. Based on the results of our annual impairment testing in 2018 and 2017, we determined that the fair value of each reporting unit substantially exceeded its carrying value and no further goodwill impairment assessment was necessary.

Other intangible assets resulting from our acquisitions include provider networks, broker networks, trademarks, state contracts, non-compete agreements, licenses and permits. We amortize other intangible assets over their estimated useful lives ranging from approximately one to 15 years. These assets are allocated to reporting units for impairment testing purposes. We review our other intangible assets for impairment when events or changes in circumstances occur, which may potentially affect the estimated useful life or recoverability of the remaining balances of our intangible assets. Such events and changes in circumstances would include significant changes in membership, state funding, federal and state government contracts and provider networks. Upon such an occurrence, recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to current forecasts of undiscounted future net cash flows expected to be generated by the assets. Identifiable cash flows are measured at the lowest level for which they are largely independent of the cash flows of other groups of assets and liabilities. If these assets are determined to be impaired, the amount of impairment recognized is measured by the amount by which the carrying amount of the assets exceeds their fair value.

During 2018 and 2017, no events or circumstances have occurred, which may potentially affect the estimated useful life or recoverability of the remaining balances of our other intangible assets. Accordingly, there were no impairment losses recognized during these periods.

T. Medicaid Premium Taxes

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 $10,737 and $8,422 for the years ended December 31, 2018 and 2017, respectively.

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.

On February 9, 2018, the Bipartisan Budget Act of 2018 was enacted, which among other things, extended Children's Health Insurance Program (“CHIP”) for an additional four years, until 2027, added additional flexibility to how Accountable Care Organizations (“ACOs”) can operate and accelerated the timing of the closure of the Part D “coverage gap” (i.e., the dollar threshold at which an individual has to pay full price for his or her medications). As a result, Part D beneficiaries' co-pays will be reduced to 25% of prescription costs in 2019, instead of that reduction occurring in 2020 under prior law. In addition, MA special needs plans were permanently reauthorized, but additional requirements for care coordination and integration of long-term services and supports were imposed. We are still assessing the affect these changes may have on our business.

The ACA included a number of changes that affected the way plans operate, such as reduced Medicare premium rates, CMS Star Ratings, minimum MLRs 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 2020. 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 2019 and 2018 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 lower-income members than average, 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.

Other Provisions

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019. After 2019, the provider fee schedules will also adjust rates based on quality performance. This Act also provided for incentive payments for those providers that participate in an alternative payment model, such as a demonstration program. Beginning in 2019, the Act also provides that we are required to pay out of network providers an additional quality-related payment pursuant to the Merit Based Incentive Payment System. These increases may increase our medical expenses and adversely affect our results of operations, financial condition and cash flows.

The ACA also established Medicare Shared Savings ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service ("FFS") program, which covers the majority of the Medicare-eligible population. CMS established the Medicare Shared Service Program (“MSSP”) to facilitate coordination and cooperation among providers to improve the quality of care for FFS beneficiaries and reduce unnecessary costs. The MSSP shares savings with the ACOs when they generate savings above a minimum savings rate and meet quality of care performance standards. The future of the ACOs is uncertain given the uncertain funding status of the ACA, or its modification.

In December 2018, a Texas federal district court ruled that the ACA was unconstitutional. Implementation of the ruling has been stayed pending appeal. If the ruling is ultimately upheld, the membership in our states that have expanded Medicaid eligibility may be reduced, which may adversely affect our results of operations.

The reforms in the ACA present both challenges and opportunities for Medicaid plans. The reforms provide states the option to expand eligibility for Medicaid programs. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current and expansion populations. As a result, the effects of any potential future expansions are uncertain, including whether states that have expanded will maintain their expansion, making it difficult to determine whether the net effect of the ACA, or any replacement or modification, will be positive or negative for Medicaid plans.

The Company is subject to the annual industry fee under section 9010 of ACA. The industry fee is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S health insurers in the year preceding the assessment. In December 2015, President Obama signed the Consolidated Appropriations Act, 2016 which, among other provisions, included a one-year moratorium on the ACA industry fee for 2017. While the ACA industry fee was assessed in 2018, the continuing resolution approved in January 2018 provides for an additional one-year moratorium for 2019 for the ACA industry fee.

The liability and expense are recognized once the Company provides health insurance for any U.S. health risk in the assessment year. The Company paid and expensed $8,925 and $0 in 2018 and 2017, respectively.

NOTE 4 - PROPERTY AND EQUIPMENT, NET

Property and equipment, net consist of the following:

	2018	2017
Property and equipment		
Furniture and fixtures	$ 195	$ 195
Computer and office equipment	1,007	993
Leasehold improvements	40	40
	1,242	1,228
Accumulated depreciation	(765)	(364)
Property and equipment, net	$ 477	$ 864

The Company recognized depreciation expense of $386 and $488 for the years ended December 31, 2018 and 2017, respectively.

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; Medical Loss Ratio of at least 85%; Administrative Cost Percentage no greater than 10%; and Equity per member of $150 (equity per member figures are not rounded to thousands) for CYE2019, $200 for CYE2020, and $250 for CYE2021 and thereafter. Once the $250 equity per member is attained, the Company must maintain compliance with that through the remainder of the contract term. For 2017, the equity per member amount was $170 (Equity per member figures are not rounded to thousands) for Contractors with enrollment less than 100 and $115 for Contractors with enrollment greater than 100. The Company is in compliance with all four ratios for fiscal year 2018 and 2017. 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.

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, was effective for the period March 1, 2017 through December 31, 2017. The Care1st bond was renewed through December 31, 2018 for an amount of $41,000. In October 2018, this Bond was increased to $63,000 and expires September 30, 2019. The Surety Bond executed by One Care, for the amount of $2,500, was effective for the period of March 1, 2017 through December 31, 2017. It was renewed through December 31, 2019 and remains in the amount of $2,500. 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 which was previously held as a deposit with the State of Arizona. As of December 31, 2018 and 2017, $5 has been recorded as a restricted regulatory deposit held by the Arizona State Treasurer as security for performance of obligations under the TPA's license with the Arizona Department of Insurance.

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, 2018 and 2017.

NOTE 7 – MEDICAL CLAIMS PAYABLE

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

	2018		2017	
Gross medical claims payable balance at January 1,	$	43,877	$	36,724
Reinsurance recoverable		(4,409)		(3,659)
Balance at January 1, net	$	39,468	$	33,065
Amount incurred related to:				
Current year		482,804		400,290
Prior years		(889)		(6,196)
Total incurred		481,915		394,094
Amounts paid related to:				
Current year		(410,890)		(361,411)
Prior years		(38,578)		(26,280)
Total paid		(449,468)		(387,691)
Balance at December 31, net	$	71,915	$	39,468
Reinsurance recoverable at December 31,	$	6,942	$	4,409
Gross medical claims payable balance at December 31,	$	78,857	$	43,877

The estimated cost of incurred claims expense attributable to prior year dates of service decreased by $889 and $6,792 during 2018 and 2017, respectively. 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, 2018 and 2017 was affected by approximately ($2,265) and $4,408, respectively, of net (unfavorable)/favorable development related to prior years.

The net unfavorable development in 2018 was driven by higher than expected utilization and changes in member mix. The net favorable development recognized in 2017 was primarily due to a number of operational and clinical initiatives planned and executed, throughout 2016, that contributed to lower than expected pharmacy and medical trends, and actual claim submission time being faster than we originally assumed (i.e. our completion factors were higher than we originally assumed) in establishing our medical benefits payable in the prior years. This development does not directly correspond to an increase in our current year operating results as these reductions were offset by estimated current period medical benefits expense when we established our estimate of the current year medical benefits payable. Both completion factor and medical trend assumptions are influenced by utilization levels, unit costs, mix of business, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, our ability and practices to manage medical and pharmaceutical costs, claim submission patterns and operational changes resulting from business combinations, among others.

The following tables provide information about incurred and paid claims development as of December 31, 2018 and 2017, net of reinsurance.

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2018	
	Incurred amount			
Incurred Year	2017	2018	Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2017	$ 400,290	$ 399,401	$ —	3,433,083
2018		482,804	$ 71,915	3,697,906
		$ 882,205		

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	2017	2018
2017	$ (361,411)	$ (399,401)
2018		(410,890)
		$ (810,291)
All outstanding liabilities before 2017, net of reinsurance		—
Liabilities for claims and claim adjustment expenses, net of reinsurance		$ 71,914

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2017	
	Incurred amount			
Incurred Year	2016	2017	Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2016	$ 340,230	$ 334,034	$ —	2,992,454
2017		400,290	$ 39,468	3,413,342
		$ 734,324		

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	**2016**	**2017**
2016	$ (307,234)	$ (334,034)
2017		(361,411)
		$ (695,445)
All outstanding liabilities before 2016, net of reinsurance		—
Liabilities for claims and claim adjustment expenses, net of reinsurance		$ 38,879

NOTE 8 - INCOME TAXES

The Company was included in the consolidated federal tax return of WellCare for the fiscal year 2018. The following table provides the components of income tax expense:

	2018	2017
Current		
Federal	$ 5,178	$ 3,747
State	938	344
	6,116	4,091
Deferred		
Federal	(357)	562
State	(85)	45
	(442)	607
Income tax expense	$ 5,674	$ 4,698

A reconciliation of income tax at the statutory federal rate of 21% (35% for 2017) to income tax at the effective rate is as follows:

	2018	2017
Income tax benefit at statutory federal rate	$ 3,263	$ 4,442
ACA insurer fee	1,874	—
State income tax, net of federal benefit	674	254
Tax rate change	(6)	72
Other, net	(131)	(70)
Total income tax expense	$ 5,674	$ 4,698

Significant components of our deferred tax assets and liabilities are:

	2018	2017
Deferred tax assets		
Employee benefits	$ 45	$ 48
Medical and other benefits discounting	631	317
Total deferred tax assets	676	365
Deferred tax liabilities		
Depreciation	(38)	(80)
Other, net	(71)	(160)
Total deferred tax liabilities	(109)	(240)
Net deferred tax assets	$ 567	$ 125

NOTE 9 - RELATED PARTY TRANSACTIONS

The Company was acquired by WCMG on December 31, 2016 from Care1st CA. The Company has $1,206 and $1,205, due from Care1st CA as of December 2018, and 2017, respectively.

Comprehensive Health Management, Inc.
The Company has an affiliated management agreement with Comprehensive Health Management, Inc ("CHMI") to provide certain management, administrative services, claims processing services, utilization review, payroll services and the majority of the administrative functions of the Company, excluding certain sales and marketing functions and other professional consulting expenses. Additionally, CHMI is responsible for maintaining the claims related data processing equipment and software.

In 2018, the Company's agreement with CHMI was amended. The indirect cost charge for Medicaid gross premium earned was revised from 1.75% in 2017 to 4.0% in 2018, with all changes being retroactive to January 1, 2018. The agreement was approved by AHCCCS on September 25, 2018.

The Company will also reimburse CHMI for expenses it pays which are directly allocable to the Company. Additionally, the agreement includes a true-up mechanism where the management fee charged is compared to the actual cost of services provided and any difference is settled between CHMI and the Company. The true-up will occur on an annual basis for the prior year's activity. Management believes rates charged by CHMI to be a fair and reasonable approximation of current market rates for the services provided; however, future adjustments to this rate may be necessary as changes in regulations, scopes of services and market dynamics occur. During 2018, the Company's 2017 management fee true-up was calculated and booked. The true-up resulted in a $2,055 decrease in management fees charged to the Company based on actual cost of services provided during 2017.

During 2018 and 2017, the Company incurred $50,547 and $37,389 respectively, for services under the management agreement with CHMI. The total amount due to CHMI were $3,051 and $4,775 at December 31, 2018 and 2017, respectively.

On August 18, 2017, the Company completed an AHCCCS approved $30,000 equity transfer to WCMG. On May 12, 2017, WCMG made a capital contribution to One Care of $2,000. On September 13, 2017, WCMG made a capital contribution of $3,000 to One Care.

NOTE 10 - COMMITMENTS AND CONTINGENCIES

WellCare 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 combined financial position of the Company. Preliminary results for the contract year ended September 30, 2017 have been issued by AHCCCS, however, there has been no notice of potential sanctions for measures where the plan did not meet the MPS. MPS results have not been issued for the contract year ended September 30, 2018.

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, claims for indemnification under purchase agreements, 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 financial statements. 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 $1,304 and $1,216 in selling general and administrative expense for the years ended December 31, 2018 and 2017, respectively, 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, 2018 are as follows:

	Minimum Lease Payments	
2019	$	369
2020		185
2021		188
2022		192
2023		195
2024		199
2025		202
2026		206
2027		209
2028		213
2029		216
Total	$	2,374

NOTE 11 – GOODWILL AND OTHER INTANGIBLE ASSETS, NET

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 resulted in $8,330 of goodwill and $4,600 of other intangible assets for Medicaid business.

	As of December 31, 2018			
	Weighted Average Amortization Period (In Years)	Gross Carrying Amount	Accumulated Amortization	Other Intangibles, Net
Membership contracts	7	$ 4,400	$ (1,050)	$ 3,350
Provider contracts	5	$ 200	$ (64)	$ 136
Total other intangible assets		$ 4,600	$ (1,114)	$ 3,486

NOTE 12 - SUBSEQUENT EVENTS

The Company has evaluated subsequent events for potential recognition and/or disclosure through April 5, 2019, the date the combined financial statements are available to be issued.

On March 26, 2019, WellCare entered into an Agreement and Plan of Merger (the “Merger Agreement”) with Centene Corporation. The Merger Agreement is subject to approval by Centene and WellCare shareholders, conditioned on clearance under the Hart-Scott Rodino Act, receipt of required state regulatory approvals and other customary closing conditions. The transaction is expected to close in the first half of 2020. Currently management does not know what, if any, effect the transaction will have on the Company.

Supplemental Detailed Balance Sheet As of December 31, 2018

ASSETS	AHCCCS	DDD	Corporate and Other	Total Care1st	Care1st Administrative Services	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Current assets										
Cash and cash equivalents	$ 173,533	$ 2,160	$ —	$ 175,693	$ 1,761	$ —	$ 177,454	$ 8,294	$ —	$ 185,748
Income tax receivable	—	—	—	—	36	—	36	704	—	740
Premiums Receivable	6,314	—	—	6,314	—	—	6,314	881		7,195
Prepaid expenses and other	10,821	907	—	11,728	—	—	11,728	856	—	12,584
Total current assets	190,668	3,067	—	193,735	1,797	—	195,532	10,735	—	206,267
Noncurrent assets										
Restricted deposits	—	—	—	—	5	—	5	—	—	5
Other receivables from government partners	—	—	—	—	—	—	—	119	—	119
Investment in subsidiaries	—	—	404	404	—	(404)	—	—	—	—
Due from affiliates	—	2,995	—	2,995	—	(1,291)	1,704	—	—	1,704
Deferred tax assets	533	—	—	533	—	—	533	34	—	567
Property and equipment, net	477	—	—	477	—	—	477	—	—	477
Goodwill	8,330	—	—	8,330	—	—	8,330	—	—	8,330
Other intangibles	3,486	—	—	3,486	—	—	3,486	—	—	3,486
Total assets	$ 203,494	$ 6,062	$ 404	$ 209,960	$ 1,802	$ (1,695)	$ 210,067	$ 10,888	$ —	$ 220,955

See notes to the supplemental schedules and the preceding combined financial statements

Supplemental Detailed Balance Sheet As of December 31, 2018

LIABILITIES AND STOCKHOLDER'S EQUITY	AHCCCS	DDD	Corporate and Other	Total Care1st	Care1st Administrative Services	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Current liabilities										
Medical claims payable:										
Hospitalization	$ 29,367	$ 614	$ —	$ 29,981	$ —	$ —	$ 29,981	$ 2,436	$ —	$ 32,417
Physician	28,523	265	—	28,788	—	—	28,788	1,026	—	29,814
Other medical expenses	15,539	274	—	15,813	—	—	15,813	813	—	16,626
PPC expenses	—	—	—	—	—	—	—	—	—	—
Total medical claims payable	73,429	1,153	—	74,582	—	—	74,582	4,275	—	78,857
Other payables to government partners	70,013	—	—	70,013	—	—	70,013	—	—	70,013
Due to affiliates	4,503	—	—	4,503	1,291	(1,291)	4,503	337	—	4,840
Income taxes payable	900			900	—	—	900	—	—	900
Accounts payable and accrued expenses	10,518	564	—	11,082	107	—	11,189	1,281	—	12,470
Total current liabilities	159,363	1,717	—	161,080	1,398	(1,291)	161,187	5,893	—	167,080
Additional paid-in capital	1,347	(5,500)	3,767	(386)	—	—	(386)	13,000	—	12,614
Retained earnings (deficit)	42,784	9,845	(3,363)	49,266	404	(404)	49,266	(8,005)	—	41,261
Total stockholder's equity	44,131	4,345	404	48,880	404	(404)	48,880	4,995	—	53,875
Total liabilities and stockholder's equity	$ 203,494	$ 6,062	$ 404	$ 209,960	$ 1,802	$ (1,695)	$ 210,067	$ 10,888	$ —	$ 220,955

See notes to the supplemental schedules and the preceding combined financial statements

Supplemental Detailed Balance Sheet As of December 31, 2017

ASSETS	AHCCCS	DDD	Corporate and Other	Total Care1st	Care1st Administrative Services	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Current assets										
Cash and cash equivalents	$ 145,284	$ 2,160	$ —	$ 147,444	$ 1,761	$ —	$ 149,205	$ 7,189	$ —	$ 156,394
Income tax receivable	1,063	—	—	1,063	10	—	1,073	(394)	—	679
Premiums Receivable	—	—	—	—	—	—	—	1,017	—	1,017
Prepaid expenses and other	6,666	49	—	6,715	—	—	6,715	60	—	6,775
Total current assets	153,013	2,209	—	155,222	1,771	—	156,993	7,872	—	164,865
Noncurrent assets										
Restricted deposits	—	—	—	—	5	—	5	—	—	5
Investment in subsidiaries	—	—	413	413	—	(413)	—	—	—	—
Due from affiliates	—	3,147	—	3,147	—	(1,268)	1,879	3,427	—	5,306
Deferred tax assets	86	—	—	86	—	—	86	39	—	125
Property and equipment, net	864	—	—	864	—	—	864	—	—	864
Goodwill	8,330	—	—	8,330	—	—	8,330	—	—	8,330
Other intangibles	4,157	—	—	4,157	—	—	4,157	—	—	4,157
Total assets	$ 166,450	$ 5,356	$ 413	$ 172,219	$ 1,776	$ (1,681)	$ 172,314	$ 11,338	$ —	$ 183,652

See notes to the supplemental schedules and the preceding combined financial statements

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
SUPPLEMENTAL INFORMATION AS OF AND FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

Supplemental Detailed Balance Sheet As of December 31, 2017

LIABILITIES AND STOCKHOLDER'S EQUITY	AHCCCS	DDD	Corporate and Other	Total Care1st	Care1st Administrative Services	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Current liabilities										
Medical claims payable:										
Hospitalization	$ 11,602	$ 419	$ —	$ 12,021	$ —	$ —	$ 12,021	$ 2,595	$ —	$ 14,616
Physician	13,664	195	—	13,859	—	—	13,859	1,211	—	15,070
Other medical expenses	10,773	225	—	10,998	—	—	10,998	1,392	—	12,390
PPC expenses	1,801	—	—	1,801	—	—	1,801	—	—	1,801
Total medical claims payable	37,840	839	—	38,679	—	—	38,679	5,198	—	43,877
Other payables to government partners	69,065	—	—	69,065	—	—	69,065	—	—	69,065
Due to affiliates	10,143	—	—	10,143	1,268	(1,268)	10,143	—	—	10,143
Accounts payable and accrued expenses	15,618	4	—	15,622	95	—	15,717	839	—	16,556
Total current liabilities	132,666	843	—	133,509	1,363	(1,268)	133,604	6,037	—	139,641
Additional paid-in capital	1,347	(5,500)	3,767	(386)	—	—	(386)	13,000	—	12,614
Retained earnings (deficit)	32,437	10,013	(3,354)	39,096	413	(413)	39,096	(7,699)	—	31,397
Total stockholder's equity	33,784	4,513	413	38,710	413	(413)	38,710	5,301	—	44,011
Total liabilities and stockholder's equity	$ 166,450	$ 5,356	$ 413	$ 172,219	$ 1,776	$ (1,681)	$ 172,314	$ 11,338	$ —	$ 183,652

See notes to the supplemental schedules and the preceding combined financial statements

Supplemental Income Statement For the Year Ended December 31, 2018

	AHCCCS	DDD	Corporate and Other	Total Care1st	Care1st Administrative Services	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Revenue										
Premium revenue										
Capitation	531,968	5,526	—	537,494	—	—	537,494	27,427	—	564,921
Delivery	19,767	—	—	19,767	—	—	19,767	—	—	19,767
Settlement	(26,370)	—	—	(26,370)	—	—	(26,370)	—	—	(26,370)
Other	9,752	127	—	9,879	(12)	—	9,867	—	—	9,867
Total premium revenue, net	$ 535,117	$ 5,653	$ —	$ 540,770	$ (12)	$ —	$ 540,758	$ 27,427	$ —	$ 568,185
Income from investment in subsidiaries	—	—	(9)	(9)	—	9	—	—	—	—
Interest income	2,640	—	—	2,640	—	—	2,640	10	—	2,650
Total revenue	537,757	5,653	(9)	543,401	(12)	9	543,398	27,437	—	570,835
Operating Expenses										
Healthcare services										
Hospitalization	104,602	2,235	—	106,837	—	—	106,837	7,016	—	113,853
Physician	139,065	1,001	—	140,066	—	—	140,066	6,648	—	146,714
Other	230,690	3,027	—	233,717	—	—	233,717	8,119	—	241,836
Reinsurance	(19,329)	(1,126)	—	(20,455)	—	—	(20,455)	(33)	—	(20,488)
Total healthcare services, net	455,028	5,137	—	460,165	—	—	460,165	21,750	—	481,915
Selling, general and administrative expenses	48,347	518	—	48,865	—	—	48,865	3,798	—	52,663
Depreciation and amortization expense	1,040	17	—	1,057	—	—	1,057	—	—	1,057
Premium tax expense	10,737	—	—	10,737	—	—	10,737	—	—	10,737
Health Insurance Providers Fee	8,285	97	—	8,382	—	—	8,382	543	—	8,925
Total expenses	523,437	5,769	—	529,206	—	—	529,206	26,091	—	555,297
Income (loss) before income taxes	14,320	(116)	(9)	14,195	(12)	9	14,192	1,346	—	15,538
Income tax expense (benefit)	5,196	52	—	5,248	(3)	—	5,245	429	—	5,674
Net income (loss)	$ 9,124	$ (168)	$ (9)	$ 8,947	$ (9)	$ 9	$ 8,947	$ 917	$ —	$ 9,864

Supplemental Income Statement For the Year Ended December 31, 2017

	AHCCCS	DDD	Corporate and Other	Total Care1st	Care1st Administrative Services	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Revenue										
Premium revenue										
Capitation	442,737	5,149	—	447,886	—	—	447,886	28,045	—	475,931
Delivery	19,637	—	—	19,637	—	—	19,637	—	—	19,637
Settlement	(42,195)	—	—	(42,195)	—	—	(42,195)	—	—	(42,195)
Other	926	45	—	971	144	—	1,115	—	—	1,115
Total premium revenue, net	$ 421,105	$ 5,194	$ —	$ 426,299	$ 144	$ —	$ 426,443	$ 28,045	$ —	$ 454,488
Income from investment in subsidiaries	—	—	87	87	—	(87)	—	—	—	—
Interest income	853	—	—	853	—	—	853	2	—	855
Total revenue	421,958	5,194	87	427,239	144	(87)	427,296	28,047	—	455,343
Operating Expenses										
Healthcare services										
Hospitalization	80,423	1,329	—	81,752	—	—	81,752	9,603	—	91,355
Physician	113,627	960	—	114,587	—	—	114,587	9,249	—	123,836
Other	183,037	2,146	—	185,183	—	—	185,183	7,397	—	192,580
Reinsurance	(13,524)	(153)	—	(13,677)	—	—	(13,677)	—	—	(13,677)
Total healthcare services, net	363,563	4,282	—	367,845	—	—	367,845	26,249	—	394,094
Selling, general and administrative expenses	34,614	406	—	35,020	6	—	35,026	4,175	—	39,201
Depreciation and amortization expense	913	18	—	931	—	—	931	—	—	931
Premium tax expense	8,422	—	—	8,422	—	—	8,422	—	—	8,422
Total expenses	407,512	4,706	—	412,218	6	—	412,224	30,424	—	442,648
Income before income taxes	14,446	488	87	15,021	138	(87)	15,072	(2,377)	—	12,695
Income tax expense	5,823	146	—	5,969	51	—	6,020	(1,322)	—	4,698
Net income (loss)	$ 8,623	$ 342	$ 87	$ 9,052	$ 87	$ (87)	$ 9,052	$ (1,055)	$ —	$ 7,997

Care1st Health Plan Arizona, Inc. - AHCCCS
Quarter Ended: 12/31/2018
Sub-Capitated Expenses Report

EXCLUDE PCP ENHANCED PARITY PAYMENTS

Account	Account Description	Amount	YTD Amount
Sub-Capitated Hospitalization Expenses:			
50105-01	Hospital Inpatient	—	—
50110-01	Hospital Inpatient -Behavioral Health Services	—	—
50115-01	RESERVED	—	—
	Total Sub-Capitated Hospitalization Expense:	—	—
Sub-Capitated Medical Compensation Expenses:			
50205-01	Primary Care Physician Services	$ 192,981	$ 861,386
50210-01	Behavioral Health Physician Services	—	—
50215-01	Referral Physician Services	—	—
50220-01	PH FQHC/RHC Services	—	—
50225-01	Other Professional Services	—	—
	Total Sub-Capitated Medical Compensation Expenses:	$ 192,981	$ 861,386
Sub-Capitated Other Medical Expenses:			
50325-01	Durable Medical Equipment	$ 1,137,968	$ 3,776,214
50330-01	Dental	$ 5,893,361	$ 18,947,631
50335-01	Transportation	$ 1,335,492	$ 3,298,232
50340-00	Nursing Facility, Home Health Care	$ 263,169	$ 924,614
50345-01	Therapies	—	—
50355-25	All Other Behavioral Health Services	—	—
50370-01	Other Medical Expenses	—	—
	Total Sub-Capitated Other Medical Expenses:	$ 8,629,990	$ 26,946,691
	Total Sub-Capitated Expenses:	$ 8,822,971	$ 27,808,077

Care1st Health Plan Arizona, Inc. - DDD
Quarter Ended: 12/31/2018
Sub-Capitated Expenses Report

EXCLUDE PCP ENHANCED PARITY PAYMENTS

Account	Account Description	Amount	YTD Amount
Sub-Capitated Hospitalization Expenses:			
50105-01	Hospital Inpatient	—	—
50110-01	Hospital Inpatient -Behavioral Health Services	—	—
50115-01	RESERVED	—	—
	Total Sub-Capitated Hospitalization Expense:	—	—
Sub-Capitated Medical Compensation Expenses:			
50205-01	Primary Care Physician Services	—	—
50210-01	Behavioral Health Physician Services	—	—
50215-01	Referral Physician Services	—	—
50220-01	PH FQHC/RHC Services	—	—
50225-01	Other Professional Services	—	—
50230-01	RESERVED	—	—
	Total Sub-Capitated Medical Compensation Expenses:	—	—
Sub-Capitated Other Medical Expenses:			
50325-01	Durable Medical Equipment	$ 10,927	$ 40,718
50330-01	Dental	$ 82,893	$ 288,697
50335-01	Transportation	$ 8,901	$ 31,426
50340-00	Nursing Facility, Home Health Care	$ 2,559	$ 10,188
50345-01	Therapies	—	—
50370-01	Other Medical Expenses	—	—
	Total Sub-Capitated Other Medical Expenses:	$ 105,280	$ 371,029
	Total Sub-Capitated Expenses:	$ 105,280	$ 371,029

NOTE 1 - BASIS OF PRESENTATION

As described more fully in Note 1 to the attached Combined Financial Statements, Care1st Health Plan Arizona, Inc. (“Care1st”) and One Care by Care1st Health Plan Arizona, Inc. (“One Care), combined (the “Company”) are wholly owned subsidiaries 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.

The supplemental information has been derived from, and should be read in conjunction with, the attached Financial Statements. Accounting policies for the Reporting Entities are the same as those described in Note 2 of Notes to the Financials Statements.

Principles of Combination

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 intercompany transactions and accounts of Care1st Health Plan Administrative Services, Inc. (“TPA”). a wholly-owned subsidiary of Care1st, have been eliminated in combination.

NOTE 2 – SUBSIDIARY AND RELATED PARTY TRANSACTIONS

Investment in Subsidiaries

The Care1st investment in TPA is stated at cost, plus equity in undistributed earnings, and is included in the Investment in Subsidiaries line in the Supplemental Detailed balance sheet. The income from TPA is included in the Care1st Income from Investment in Subsidiaries line item on the Supplemental Income Statement.

Eliminations

Intercompany transactions and balances are eliminated in combination. Eliminations between Care1st and TPA are reflected in the “Eliminations” column in the Supplemental Detailed balance sheet and Supplemental Income Statement.

NOTE 3 – STOCKHOLDER’S EQUITY

On August 18, 2017, the Company completed an AHCCCS approved $30,000 equity transfer to WCMG. On May 12, 2017, WCMG made a capital contribution to One Care of $2,000. On September 13, 2017, WCMG made a capital contribution of $3,000 to One Care.