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, 2017 and 2016, Supplemental Schedules as of and for the years ended December 31, 2017 and 2016, and Independent Auditors' Report

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

TABLE OF CONTENTS

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, 2017 and 2016, and the related combined statements of income, changes in stockholder's equity, and cash flows 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 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 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 as of December 31, 2017 and 2016, 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 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 26 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.

May 8, 2018

CARE1ST HEALTH PLAN ARIZONA, INC.
AND ONE CARE BY CARE1ST HEALTH PLAN ARIZONA, INC.
COMBINED BALANCE SHEETS AS OF DECEMBER 31, 2017 AND 2016

(amounts in thousands)

ASSETS	2017	2016
Current assets		
Cash and cash equivalents	$ 156,394	$ 121,574
ACA reimbursement receivable	-	8,991
Income tax receivable	679	-
Prepaid expenses and other	7,792	5,356
Total current assets	164,865	135,921
Restricted deposits	5	32,505
Deferred tax assets	125	732
Due from affiliates	5,306	-
Property and equipment, net	864	1,458
Goodwill	8,330	-
Other intangibles	4,157	-
Total assets	$ 183,652	$ 170,616
LIABILITIES AND STOCKHOLDER'S EQUITY		
Current liabilities		
Medical claims payable	$ 43,877	$ 36,724
Accounts payable and accrued expenses	16,556	7,824
Due to affiliates	10,143	-
Other payables to government partners	69,065	60,649
Income tax payable	-	4,405
Total current liabilities	139,641	109,602
Additional paid-in capital	12,614	7,614
Retained earnings	31,397	53,400
Total stockholder's equity	44,011	61,014
Total liabilities and stockholder's equity	$ 183,652	$ 170,616

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, 2017 AND 2016

(amounts in thousands)	2017	2016
Revenue		
Net premium revenue	$ 454,488	$ 404,677
Net investment income	855	224
Total revenue	455,343	404,901
Operating expenses		
Healthcare services, net	394,095	336,690
Selling, general and administrative expenses	39,200	35,371
Depreciation and amortization expense	931	625
Premium tax expense	8,422	7,510
ACA fee expense	-	6,076
Interest expense	-	42
Total expenses	442,648	386,314
Income before income taxes	12,695	18,587
Income tax expense	4,698	8,814
Net income	$ 7,997	$ 9,773

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, 2017 AND 2016

(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, 2016	2,000	$ 7,614	$ 43,627	$ 51,241
Net income	-	-	9,773	9,773
Balance, December 31, 2016	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

* *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, 2017 AND 2016

(amounts in thousands)

	2017	2016
Cash flows from operating activities		
Net income	$ 7,997	$ 9,773
Adjustments to reconcile net income to cash provided by operating activities		
Depreciation & amortization expense	931	625
Deferred taxes, net	607	(77)
Other, net	106	(28)
Changes in operating accounts:		
ACA reimbursement receivable	8,991	(8,991)
Unearned premiums	-	(3,071)
Prepaid expenses, other assets and deposits	802	1,229
Payables to government partners	8,416	5,783
Accounts payable and accrued expenses	8,733	2,561
Medical claims payable and other medical liabilities	7,153	4,562
Income tax receivable/payable	(5,085)	(5,054)
Other, net	1,599	249
Net cash provided by operating activities	40,250	7,561
Cash flows from investing activities		
Business Acquisition - Phoenix Health Plans	(12,930)	-
Purchase of property and equipment	-	(648)
Additions / (reductions) to restricted cash	32,500	(15,000)
Net cash provided by (used in) investing activities	19,570	(15,648)
Cash flows from financing activities		
Contributions/equity transfers, net	(25,000)	-
Net cash used in financing activities	(25,000)	-
Net change in cash and cash equivalents	34,820	(8,087)
Cash and cash equivalents, beginning of year	121,574	129,661
Cash and cash equivalents, end of year	$ 156,394	$ 121,574
Supplemental disclosures of cash flow information:		
Cash paid for interest	$ -	$ 42
Cash paid for taxes	$ 4,771	$ 11,250

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 dba Blue Shield of California. As of December 31, 2017 and 2016, the Company provided benefits to 152,686 and 117,173 Medicaid members, respectively. As of December 31, 2017 and 2016, the Company provided benefits to 2,097 and 2,021 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. 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 Medicare Advantage ("MA") health plans and prescription drug benefits to Medicare beneficiaries through the Medicare Part D Program ("PDP"). 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.

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 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, 2018.

On March 13, 2018 the Company announced that it was selected to enter into a contract with AHCCCS to coordinate the provision of physical and behavioral healthcare services in the Cental and North georgraphic service areas, beginning October 1, 2018.

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"). Certain prior year amounts have been reclassified to conform to the current year's presentation. We evaluated all material events subsequent to the date of these financial statements.

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 intercompany 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 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 income, 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 have not been materially different from our estimates.

(DOLLAR AMOUNTS IN THOUSANDS)

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 a component of prepaid expenses and other on the balance sheet. 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, 2017 and 2016.

J. 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, 2017 and 2016, the Company recorded a net payable of $69,065 and $60,649, respectively, 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.

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 refunds of $1,544 for Calendar Year End ("CYE") 2015, $27,659 for CYE2016, $31,655 for CYE2017 and $8,207 for CY2018 which are recorded as other payables to government partners on the balance sheet. During 2017, $32,036 was paid related to CYE2015; however, the Prospective liability period will be reconciled in the future. As of December 31, 2016, the Company accrued $33,580 for CYE 2015, $26,334 for CYE 2016 and $735 for CYE 2017, which were recorded as a component of other payables to government partners on the balance sheet, and have been partially paid out to AHCCCS in 2017.

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 rates October 2017 – September 2018. The ACOM policies have not been updated yet, however, the Market received confirmation of the new reconciliation process from AHCCCS. 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 $6,071 for the period between October 2017 – December 2017 which is recorded as a component of other payables to government partners on the balance sheet.

Medicare Minimum Loss Ratio

Beginning in 2014, the Patient Protection and Affordable Care Act, as 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 2017 or 2016.

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 reserves for life and accident and health contracts. Once established, a PDR is reduced over the contract period as an offset to actual losses. The PDR estimates are re-evaluated each reporting period and, if estimated future losses differ from those in the current PDR estimate, the liability is adjusted through increase in reserves for life and accident and health contracts, as necessary. The Company had no PDR liability recorded within its liabilities as of December 31, 2017 and 2016.

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 $12,725 and $9,700 of reinsurance revenues in healthcare services, net for the years ended December 31, 2017 and 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.

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, 2017, Care1st accrued the 1% maximum liability. There was nothing accrued in 2016.

Risk-Adjusted Premiums
CMS provides risk-adjusted payments for MA Plans and PDPs 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 earned premiums 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 contract terms and record amounts as a reduction of recorded direct medical expenses.

Unpaid claims 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 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;
- 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 unpaid 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 healthcare services, net 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 selling, general and administrative expenses in the Statements of Income as they are incurred.

O. Advertising Costs

We record the production costs of advertising activities as general and 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 $458 and $545 for the years ended December 31, 2017 and 2016, respectively, which are included in the selling, general and administrative expenses in the Statements of Income.

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 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 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 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 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 12 - 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 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 2017 and 2016, 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 $8,422 and $7,510 for the years ended December 31, 2017 and 2016, respectively.

NOTE 3 - HEALTH CARE REFORM

In March 2010, the the Patient Protection and Affordable Care Act ("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 funding of the ACA is uncertain under the current presidential administration.

The ACA included a number of changes that affected the way plans operate, such as reduced Medicare premium rates, CMS Star Ratings, minimum medical loss ratios ("MLRs") and other provisions.

Reduced Medicare Premium Rates
In April 2017, the CMS final call letter revised the proposed 2018 MA and Part D rates. We estimate the 2018 rates, compared to 2017, will increase slightly, excluding Medicare coding trends and the return of the ACA industry fee.

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 2018 and 2017 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 fully 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.

Other Provisions

Under the ACA, over a 10-year period beginning in 2010, the "coverage gap" (i.e., the dollar threshold at which an individual has to pay full price for his or her medications) under Part D has been gradually closing, with beneficiaries retaining a 25% co-pay in 2020. While this change will ultimately result in increased insurance coverage for beneficiaries, such improved benefits could result in changes in member behavior with respect to drug utilization. Such actions could affect the cost structure of our PDPs.

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 was enacted in April 2015, which, among other things, is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019 and extended the Special Needs Program through 2018. 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. On January 22, 2018, CHIP funding was extended for six years as part of a broader continuing resolution to fund the federal government. In addition, the resolution continued the enhanced federal match rate for CHIP established by the ACA initially, but reduced the rate over time. The resolution also extended the requirement for states to maintain coverage for children from 2019 through 2023, but after October 1, 2019, the requirement is limited to children in families with incomes at or below 300% of the federal poverty level. On February 9, 2018, the Bipartisan Budget Act of 2018 was enacted, which extended CHIP for an additional four years, until 2027, and permanently reauthorized MA special needs plans but imposed additional requirements for care coordination and integration of long-term services and supports.

The ACA also established Medicare Shared Savings Accountable Care Organizations ("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.

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 will be assessed in 2018, the continuing resolution approved in January 2018 provides for an additional one-year moratorium for 2019 for the ACA industry fee.

(DOLLAR AMOUNTS IN THOUSANDS)

The re-imposition of the ACA industry fee in 2018 and any future increases to the ACA industry fee could increase our tax rates and could adversely affect our combined statements of income, changes in stockholders' equity, and cash flows.

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 $0 and $6,076 in 2017 and 2016, respectively.

NOTE 4 - PROPERTY AND EQUIPMENT, NET

Property and equipment, net consists of the following:

	2017	2016
Property and equipment		
Furniture and fixtures	195	909
Computer and office equipment	993	4,072
Leasehold improvements	40	386
	1,228	5,367
Accumulated depreciation	(364)	(3,909)
Property and equipment, net	864	1,458

The Company recognized depreciation expense of $488 and $625 for the years ended December 31, 2017 and 2016, respectively, which is recorded as depreciation and amortization expense in the statement of income.

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 (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; 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 2017 and 2016. 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, and may be extended through December 31, 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, 2018 for an amount of $2,500, and may be extended through December 31, 2019. 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 required by AHCCCS, the Company recorded as restricted cash regulatory deposits held by the Arizona State Treasurer's Office totaling $0 and $32,500 as a statutory deposit for the protection of the plan members as of December 31, 2017 and 2016, respectively. As of December 31, 2017 and 2016, $5 and $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.

(DOLLAR AMOUNTS IN THOUSANDS)

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, 2017 and 2016.

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:

	2017	2016
Gross medical claims payable balance at January 1,	$ 36,724	$ 32,162
Reinsurance recoverable	(3,659)	(2,248)
Balance at January 1, net	$ 33,065	$ 29,914
Amount incurred related to:		
Current year	400,290	340,230
Prior years	(6,196)	(3,740)
Total incurred	394,094	336,490
Amounts paid related to:		
Current year	(361,411)	(307,234)
Prior years	(26,280)	(26,105)
Total paid	(387,691)	(333,339)
Balance at December 31, net	$ 39,468	$ 33,065
Reinsurance recoverable at December 31,	$ 4,409	$ 3,659
Gross medical claims payable balance at December 31,	$ 43,877	$ 36,724

The estimated cost of incurred claims expense attributable to prior year dates of service decreased by $6,792 and $3,740 during 2017 and 2016, 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, 2017 and 2016 was affected by approximately $4,408 and $2,312, respectively, of net favorable development related to prior years.

The net favorable development recognized in both 2017 and 2016 was primarily due to a number of operational and clinical initiatives planned and executed, throughout both 2015 and 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.

(DOLLAR AMOUNTS IN THOUSANDS)

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

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2017	
	Incurred amount		Total of IBNR Liabilities Plus	Cumulative
Incurred Year	2016	2017	Expected	
2016	$ 340.2	$ 334.0	$ -	2,992,454
2017		400.3	39.5	3,413,342
	Total	$ 734.3		

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	2016	2017
2016	$ (307.2)	$ (333.4)
2017		(361.4)
	Total	$ (694.8)
	All outstanding liabilities before 2016, net of reinsurance	-
	Liabilities for claims and claim adjustment expenses, net of	$ 39.5

NOTE 8 - INCOME TAXES

The Company was included in the consolidated federal tax return of WellCare for the fiscal year 2017. 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:

	2017	2016
Current		
Federal	$ 3,747	$ 8,891
State	344	-
	4,091	8,891
Deferred		
Federal	562	(77)
State	45	-
	607	(77)
Income tax expense	$ 4,698	$ 8,814

(DOLLAR AMOUNTS IN THOUSANDS)

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

	2017	2016
Income tax benefit at statutory federal rate	$ 4,442	$ 6,506
ACA insurer fee	-	2,127
Tax rate change	72	-
Other, net	184	181
Total income tax expense	$ 4,698	$ 8,814

Significant components of our deferred tax assets and liabilities are:

	2017	2016
Deferred tax assets		
Employee benefits	$ 48	$ 594
Reinsurance allowance	-	110
Other, net	157	255
Total deferred tax assets	205	959
Deferred tax liabilities		
Depreciation	(80)	(227)
Total deferred tax liabilities	(80)	(227)
Net deferred tax assets	$ 125	$ 732

On December 22, 2017, President Trump signed the *Tax Cut and Jobs Act of 2017* (the "TCJA") into legislation which, among other things, reduced the federal income tax rate for corporations from 35% to 21% effective on January 1, 2018. We are required to recognize the effect on deferred tax assets and liabilities of a change in tax rates in the period the tax rate change was enacted. We currently expect the enacted reduction in the U.S. corporate income tax rate, as well as other aspects of the new law, to result in a one-time, non-cash decrease to income tax expense for the year ended December 31, 2017.

Consistent with Staff Accounting Bulletin No. 118 ("SAB 118"), INT 18-01, Updated Tax Estimates under the TCJA provides guidance on accounting for the tax effects of the TCJA. SAB 118 provides a measurement period that should not extend beyond one year from the TCJA enactment date for companies to complete the accounting relating to the TCJA. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the TCJA for which the accounting under ASC 740 is complete.

To the extent that a company's accounting for certain income tax effects of the TCJA is incomplete but it is able to determine a reasonable estimate, it must record a provisional estimate in its financial statements. If a company cannot determine a provisional estimate to be included in its financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the TCJA.

As we were able to make reasonable estimates of the effects of the TCJA, we recorded provisional amounts. In connection with the adoption of the TCJA, we remeasured certain deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally at a federal rate of 21%. However, we are still analyzing certain

aspects of the TCJA and refining our calculations, which could potentially affect the measurement of these balances or potentially give rise to new deferred tax amounts. Our financial statements include provisional amounts for the effects of deferred tax revaluation.

Once we finalize certain tax positions, we will be able to conclude whether any further adjustments are required to the deferred tax balances. Any adjustments to these provisional amounts will be reported as a component of tax expense (benefit) in the reporting period in which any such adjustments are determined, which should be no later than the fourth quarter of 2018.

NOTE 9 - RELATED PARTY TRANSACTIONS

The Company was acquired by WCMG on December 31, 2016 from Care1st CA. The Company has ($1,205) and $1,526, due (from) to Care1st CA as of December 2017, and 2016, respectively. The amounts due to Care1st CA primarily relate to shared services and payments made on behalf of Care1st.

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.

The Company's agreement with CHMI stipulates a 1.75% indirect cost charge for Medicaid gross premium. 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 2017, the Company incurred $37,389 for services under the management agreement with CHMI. The total amount due to CHMI was $4,775 at December 31, 2017.

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 – RETIREMENT 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 in employer contribution expense for the years ended December 31, 2016.

NOTE 11 - COMMITMENTS AND CONTINGENCIES

The Company's ultimate Parent, WellCare, remains contingently liable for certain potential obligations stemming from settlements to resolve previous government investigations and related litigation. Unless otherwise indicated, these matters

(DOLLAR AMOUNTS IN THOUSANDS)

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. MPS results have not yet been issued by AHCCCS for the contract year ended September 30, 2017.

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 $1,216 and $1,068 in selling general and administrative expense for the years ended December 31, 2017 and 2016, 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, 2017 are as follows:

	Minimum Lease Payments
2018	1,089
2019	369
Total	1,458

(DOLLAR AMOUNTS IN THOUSANDS)

NOTE 12 – 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, 2017			
	Weighted Average Amortization Period (In Years)	Gross Carrying Amount	Accumulated Amortization	Other Intangibles, Net
Membership contracts	7	$ 4,400	$ (417)	$ 3,983
Provider contracts	5	$ 200	$ (27)	$ 173
Total other intangible assets		$ 4,600	$ (443)	$ 4,157

NOTE 13 - SUBSEQUENT EVENTS

The Company has evaluated subsequent events for potential recognition and/or disclosure through May 8, 2018, the date the financial statements are available to be issued.

On March 13, 2018 the Company announced that it was selected to enter into a contract with AHCCCS to coordinate the provision of physical and behavioral healthcare services in the Cental and North georgraphic service areas, beginning October 1, 2018.

Supplemental Detailed Balance Sheet As of December 31, 2017

ASSETS	AHCCCS	DDD	Corporate and Other	Total Care1st	TPA	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
Prepaid expenses and other	6,666	49	-	6,715	-	-	6,715	1,077	-	7,792
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

Supplemental Detailed Balance Sheet As of December 31, 2017

LIABILITIES AND STOCKHOLDER'S EQUITY	AHCCCS	DDD	Corporate and Other	Total Care1st	TPA	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 expenes	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

Supplemental Detailed Balance Sheet As of December 31, 2016

ASSETS	AHCCCS	DDD	Corporate and Other	Total Care1st	TPA	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Current assets										
Cash and cash equivalents	$ 114,458	$ 2,160	$ -	$ 116,618	$ 329	$ -	$ 116,947	$ 4,627	$ -	$ 121,574
ACA reimbursement receivable	8,991	-	-	8,991	-	-	8,991	-	-	8,991
Prepaid expenses and other	5,019	116	-	5,135	35	-	5,170	186	-	5,356
Total current assets	128,468	2,276	-	130,744	364	-	131,108	4,813	-	135,921
Noncurrent assets										
Restricted deposits	30,000	-	-	30,000	5	-	30,005	2,500	-	32,505
Investment in subsidiaries	-	-	326	326	-	(326)	-	-	-	-
Due from (to) affiliates, net	690	2,195	-	2,885	(53)	-	2,832	(2,832)	-	-
Deferred tax assets	732	-	-	732	-	-	732	-	-	732
Property and equipment, net	1,458	-	-	1,458	-	-	1,458	-	-	1,458
Total assets	$ 161,348	$ 4,471	$ 326	$ 166,145	$ 316	$ (326)	$ 166,135	$ 4,481	$ -	$ 170,616

Supplemental Detailed Balance Sheet As of December 31, 2016

LIABILITIES AND STOCKHOLDER'S EQUITY	AHCCCS	DDD	Corporate and Other	Total Care1st	TPA	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Current liabilities										
Medical claims payable:										
Hospitalization	$ 7,196	$ 78	$ -	$ 7,274	$ -	$ -	$ 7,274	$ 1,207	$ -	$ 8,481
Physician	8,217	99	-	8,316	-	-	8,316	427	-	8,743
Other medical expenes	15,709	123	-	15,832	-	-	15,832	1,108	-	16,940
PPC expenses	2,560	-	-	2,560	-	-	2,560	-	-	2,560
Total medical claims payable	33,682	300	-	33,982	-	-	33,982	2,742	-	36,724
Other payables to government partners	60,649	-	-	60,649	-	-	60,649			60,649
Unearned premiums	-	-	-	-	-	-	-			-
Accounts payable and accrued expenses	7,452	-	-	7,452	(10)	-	7,442	382		7,824
Income tax payable	4,405	-	-	4,405	-	-	4,405			4,405
Total current liabilities	106,188	300	-	106,488	(10)	-	106,478	3,124	-	109,602
Additional paid-in capital	1,347	(5,500)	3,767	(386)	-	-	(386)	8,000	-	7,614
Retained earnings (deficit)	53,813	9,671	(3,441)	60,043	326	(326)	60,043	(6,643)	-	53,400
Total stockholder's equity	55,160	4,171	326	59,657	326	(326)	59,657	1,357	-	61,014
Total liabilities and stockholder's equity	$ 161,348	$ 4,471	$ 326	$ 166,145	$ 316	$ (326)	$ 166,135	$ 4,481	$ -	$ 170,616

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

Supplemental Income Statement For the Year Ended December 31, 2017

	AHCCCS	DDD	Corporate and Other	Total Care1st	TPA	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

Supplemental Income Statement For the Year Ended December 31, 2016

	AHCCCS	DDD	Corporate and Other	Total Care1st	TPA	Eliminations	Combined Care1st	One Care	Eliminations	The Company
Revenue										
Premium revenue										
Capitation	361,224	4,623	-	365,847	-	-	365,847	26,890	-	392,737
Delivery	16,754	-	-	16,754	-	-	16,754	-	-	16,754
Settlement	(22,346)	-	-	(22,346)	-	-	(22,346)	-	-	(22,346)
Other	16,099	163	-	16,262	1,270	-	17,532	-	-	17,532
Total premium revenue, net	$ 371,731	$ 4,786	$ -	$ 376,517	$ 1,270	$ -	$ 377,787	$ 26,890	$ -	$ 404,677
Income from investment in subsidiaries	-	-	25	25	-	(25)	-	-	-	-
Interest income	224	-	-	224	-	-	224	-	-	224
Total revenue	371,955	4,786	25	376,766	1,270	(25)	378,011	26,890	-	404,901
Operating Expenses										
Healthcare services										
Hospitalization	74,581	191	-	74,772	-	-	74,772	7,081	-	81,853
Physician	91,454	625	-	92,079	-	-	92,079	6,824	-	98,903
Other	151,707	2,144	-	153,851	-	-	153,851	12,719	-	166,570
Reinsurance	(10,580)	(173)	-	(10,753)	-	-	(10,753)	(83)	-	(10,836)
Total healthcare services, net	307,162	2,787	-	309,949	-	-	309,949	26,541	-	336,490
Selling, general and administrative expenses	30,566	443	-	31,009	1,230	-	32,239	3,331	-	35,570
Depreciation expense	625	-	-	625	-	-	625	-	-	625
Premium tax expense	7,510	-	-	7,510	-	-	7,510	-	-	7,510
ACA fee expense	5,614	75	-	5,689	-	-	5,689	388	-	6,077
Interest expense	42	-	-	42	-	-	42	-	-	42
Total expenses	351,519	3,305	0	354,824	1,230	0	356,054	30,260	-	386,314
Income before income taxes	20,436	1,481	25	21,942	40	(25)	21,957	(3,370)	-	18,587
Income tax expense	9,531	598	-	10,129	15	-	10,144	(1,330)	-	8,814
Net income (loss)	$ 10,905	$ 883	$ 25	$ 11,813	$ 25	$ (25)	$ 11,813	$ (2,040)	$ -	$ 9,773

Care1st Health Plan Arizona, Inc. - AHCCCS
Quarter Ended: 12/31/2017
Sub-Capitated Expenses Report
EXCLUDE PCP ENHANCED PARITY PAYMENTS

Account	Account Description	Amount	YTD Amount
Sub-Capitated Hospitalization Expenses:			
50105	Hospital Inpatient	$ -	$ -
50110	Hospital Inpatient -Behavioral Health Services	$ -	$ -
50115	PPC-Hospital Inpatient	$ -	$ -
	Total Sub-Capitated Hospitalization Expense:	$ -	$ -
Sub-Capitated Medical Compensation Expenses:			
50205	Primary Care Physician Services	$ 239,565	$ 926,302
50210	Behavioral Health Physician Services	$ -	$ -
50215	Referral Physician Services	$ -	$ -
50220	PH FQHC/RHC Services	$ -	$ -
50225	Other Professional Services	$ -	$ -
50230	PPC - Physician Services	$ -	$ -
	Total Sub-Capitated Medical Compensation Expenses:	$ 239,565	$ 926,302
Sub-Capitated Other Medical Expenses:			
50305	Emergency Facility Services	$ -	$ -
50310-01	PH Pharmacy	$ -	$ -
50315	Laboratory, Radiology and Medical Imaging	$ -	$ -
50320	Outpatient Facility	$ -	$ -
50325	Durable Medical Equipment	$ 932,254	$ 3,517,464
50330	Dental	$ 5,151,005	$ 18,658,592
50335	Transportation	$ 695,479	$ 2,523,827
50340	Nursing Facility, Home Health Care	$ 215,374	$ 744,642
50345	Therapies	$ -	$ -
50350	Alternative Payment Model Performance Based Payments to Providers	$ -	$ -
50355-01	Behavioral Health Day Program	$ -	$ -
50355-05	Behavioral Health Case Management Services	$ -	$ -
50355-10	Behavioral Health Crisis Intervention Services	$ -	$ -
50355-15	Behavioral Health Rehabilitation Services	$ -	$ -
50355-20	Behavioral Health Residential Services	$ -	$ -
50355-25	All Other Behavioral Health Services	$ -	$ -
50360	PPC-Other Medical Expenses	$ -	$ -
50370	Other Medical Expenses	$ -	$ -
	Total Sub-Capitated Other Medical Expenses:	$ 6,994,112	$ 25,444,524
	Total Sub-Capitated Expenses:	$ 7,233,677	$ 26,370,826

Care1st Health Plan Arizona, Inc. - DDD
Quarter Ended: 12/31/2017
Sub-Capitated Expenses Report
EXCLUDE PCP ENHANCED PARITY PAYMENTS

Account	Account Description	Amount	YTD Amount
Sub-Capitated Hospitalization Expenses:			
50105	Hospital Inpatient	$ -	$ -
50110	Hospital Inpatient -Behavioral Health Services	$ -	$ -
50115	PPC-Hospital Inpatient	$ -	$ -
	Total Sub-Capitated Hospitalization Expense:	$ -	$ -
Sub-Capitated Medical Compensation Expenses:			
50205	Primary Care Physician Services	$ -	$ -
50210	Behavioral Health Physician Services	$ -	$ -
50215	Referral Physician Services	$ -	$ -
50220	PH FQHC/RHC Services	$ -	$ -
50225	Other Professional Services	$ -	$ -
50230	PPC - Physician Services	$ -	$ -
	Total Sub-Capitated Medical Compensation Expenses:	$ -	$ -
Sub-Capitated Other Medical Expenses:			
50305	Emergency Facility Services	$ -	$ -
50310-01	PH Pharmacy	$ -	$ -
50315	Laboratory, Radiology and Medical Imaging	$ -	$ -
50320	Outpatient Facility	$ -	$ -
50325	Durable Medical Equipment	$ 9,131	$ 35,452
50330	Dental	$ 68,804	$ 259,982
50335	Transportation	$ 6,904	$ 26,270
50340	Nursing Facility, Home Health Care	$ 2,138	$ 7,482
50345	Therapies	$ -	$ -
50350	Alternative Payment Model Performance Based Payments to Providers	$ -	$ -
50355-01	Behavioral Health Day Program	$ -	$ -
50355-05	Behavioral Health Case Management Services	$ -	$ -
50355-10	Behavioral Health Crisis Intervention Services	$ -	$ -
50355-15	Behavioral Health Rehabilitation Services	$ -	$ -
50355-20	Behavioral Health Residential Services	$ -	$ -
50355-25	All Other Behavioral Health Services	$ -	$ -
50360	PPC-Other Medical Expenses	$ -	$ -
50370	Other Medical Expenses	$ -	$ -
	Total Sub-Capitated Other Medical Expenses:	$ 86,976	$ 329,187
	Total Sub-Capitated Expenses:	$ 86,976	$ 329,187

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

During August 2016 Care1st requested permission from the state to transfer $4,000 of equity from the regulated DDD health plan to close out a retained deficit of $3,767 on a related health plan owned by Care1st. The excess of $233 equity was transferred to the AHCCCS health plan. The transaction has no impact on a combined Care1st basis.

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.