Arizona Physicians IPA, Inc.

Financial Statements as of and for the
Years Ended December 31, 2014 and 2013,
Supplemental Schedules as of and for the
Year Ended December 31, 2014, and
Independent Auditors' Report

ARIZONA PHYSICIANS IPA, INC.

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
Arizona Physicians IPA, Inc.
3141 North 3rd Avenue
Phoenix, AZ 85013

We have audited the accompanying financial statements of Arizona Physicians IPA, Inc. (the "Company"), which comprise the balance sheets as of December 31, 2014 and 2013, and the related statements of operations, comprehensive income, changes in stockholder's equity and accumulated other comprehensive income, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements 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 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 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 financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the 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 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 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 financial statements referred to above present fairly, in all material respects, the financial position of the company as of December 31, 2014 and 2013, 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 Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information in Exhibit I, although not a part of the basic financial statements, is required by the Arizona Health Care Cost Containment System who 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 managements responses to our inquiries, the basic financial statement, and other knowledge we obtained during our audit of the basic 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.

Deloitte & Touche LLP

April 29, 2015

ARIZONA PHYSICIANS IPA, INC.

BALANCE SHEETS
AS OF DECEMBER 31, 2014 AND 2013
(In thousands, except share and per share data)

	2014	2013
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 103,283	$ 72,752
Short-term investments	6,913	8,152
Premiums receivable	29,727	25,023
AHCCCS reinsurance receivable	28,397	18,346
AHCCCS PCP enhanced rate payments receivable	10,090	17,408
Other contract program receivables	15,389	4,491
Other receivables—net of allowances of $566 and $432 in 2014 and 2013, respectively	5,699	1,652
Related-party receivable—net	3,869	513
Investment receivables	1,519	1,464
Current deferred taxes—net	928	642
Total current assets	205,814	150,443
LONG-TERM INVESTMENTS	185,671	173,054
TOTAL	$ 391,485	$ 323,497
LIABILITIES AND STOCKHOLDER'S EQUITY		
CURRENT LIABILITIES:		
Medical services payable	$ 230,877	$ 170,360
Medicaid risk sharing payable	32,442	19,517
Other payables to contract programs	-	1,952
Accounts payable and accrued expenses	7,537	13,383
Current income taxes payable	9,168	8,533
Total current liabilities	280,024	213,745
LONG-TERM DEFERRED INCOME TAXES—Net	2,045	680
Total liabilities	282,069	214,425
CONTINGENCIES (Note 6)		
STOCKHOLDER'S EQUITY:		
Common stock, $0.01 par value—1,000,000 shares authorized; two shares issued and outstanding	-	-
Additional paid-in capital	77,516	79,266
Retained earnings	28,633	28,680
Accumulated other comprehensive income	3,267	1,126
Total stockholder's equity	109,416	109,072
TOTAL	$ 391,485	$ 323,497

See notes to financial statements.

ARIZONA PHYSICIANS IPA, INC.

STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013
(In thousands)

	2014	2013
REVENUES:		
Capitation and risk-sharing settlements	$ 1,838,592	$ 1,283,611
Delivery supplemental premiums	48,548	47,135
Investment income—net	5,869	5,951
Total revenues	1,893,009	1,336,697
MEDICAL SERVICES EXPENSES:		
Hospital inpatient services	383,262	284,091
Medical compensation	482,569	331,328
Pharmacy	232,285	167,942
Outpatient facility	119,917	108,186
Emergency facility services	100,990	69,669
Nursing facility and home health care	86,741	76,483
Lab, x-ray, and medical imaging	61,524	39,183
Transportation	54,529	23,755
Dental	48,049	37,941
Other medical services	47,036	27,045
Durable medical equipment	42,805	33,887
Long-term care institutional	30,203	-
Long-term care home-based and community-based services	26,369	-
Recoveries from AHCCCS	(48,719)	(44,153)
Total medical services expenses	1,667,560	1,155,357
ADMINISTRATIVE EXPENSES	171,205	135,363
PREMIUM TAXES	27,729	18,155
Total expenses	1,866,494	1,308,875
INCOME BEFORE INCOME TAXES	26,515	27,822
PROVISION FOR INCOME TAXES	17,312	10,264
NET INCOME	$ 9,203	$ 17,558

See notes to financial statements.

ARIZONA PHYSICIANS IPA, INC.

STATEMENTS OF COMPREHENSIVE INCOME
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013
(In thousands)

	2014	2013
NET INCOME	$ 9,203	$ 17,558
OTHER COMPREHENSIVE INCOME (LOSS):		
Gross unrealized holding gains (losses) on investment securities during the period	4,040	(6,367)
Income tax effect	(1,352)	2,750
Total unrealized gains (losses)—net of tax	2,688	(3,617)
Gross reclassification adjustment for net realized gains included in net earnings	(895)	(946)
Income tax effect	348	371
Total reclassification adjustment—net of tax	(547)	(575)
Other comprehensive income (loss)	2,141	(4,192)
COMPREHENSIVE INCOME	$ 11,344	$ 13,366

See notes to financial statements.

ARIZONA PHYSICIANS IPA, INC.

STATEMENTS OF CHANGES IN STOCKHOLDER'S EQUITY AND ACCUMULATED OTHER COMPREHENSIVE INCOME
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013
(In thousands, except share data)

	Common Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income	Total Shareholder's Equity
	Shares	Amount				
BALANCE—January 1, 2013	2	$ -	$ 52,266	$ 11,122	$ 5,318	$ 68,706
Comprehensive income:						
Net income	-	-	-	17,558	-	17,558
Change in net unrealized loss on investments available-for-sale—net of tax effects and reclassification adjustments	-	-	-	-	(3,617)	(3,617)
Reclassification adjustments for net realized gains included in net loss—net of tax effects	-	-	-	-	(575)	(575)
Total comprehensive income						13,366
Infusions	-	-	27,000	-	-	27,000
BALANCE—December 31, 2013	2	-	79,266	28,680	1,126	109,072
Comprehensive income:						
Net income	-	-	-	9,203	-	9,203
Change in net unrealized gains on investments available-for-sale—net of tax effects and reclassification adjustments	-	-	-	-	2,688	2,688
Reclassification adjustments for net realized gains included in net income—net of tax effects	-	-	-	-	(547)	(547)
Total comprehensive income						11,344
Infusions	-	-	14,000	-	-	14,000
Return of stockholder's equity	-	-	(15,750)	(9,250)	-	(25,000)
BALANCE—December 31, 2014	2	$ -	$ 77,516	$ 28,633	$ 3,267	$ 109,416

See notes to financial statements.

ARIZONA PHYSICIANS IPA, INC.

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013
(In thousands)

	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net income	$ 9,203	$ 17,558
Adjustments to reconcile net income to net cash provided by operating activities:		
Amortization of investment premium—net	1,310	1,151
Deferred income taxes	(272)	1,102
Gains on sale of investments—net	(895)	(946)
Changes in operating assets and liabilities:		
Premiums receivable	(4,704)	(5,967)
AHCCCS reinsurance receivables	(10,051)	7,723
Other contract program receivables	950	1,804
Other receivables	(4,047)	609
Investment income receivable	(55)	49
Current income taxes	635	8,837
Medical services payable	60,517	24,933
Accounts payable and accrued expenses	1,729	752
Medicaid risk sharing payables	12,925	(23,477)
Other payables to contract programs	(1,952)	1,012
Related party receivable—net	(3,356)	3,486
Net cash provided by operating activities	61,937	38,626
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of investments available-for-sale	(89,478)	(60,582)
Proceeds from maturities/sales of investments available-for-sale	81,178	53,987
Net cash used in investing activities	(8,300)	(6,595)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Return of capital	(25,000)	-
Capital infusions received	14,000	27,000
Checks outstanding	(7,248)	1,112
AHCCCS funds administered	6,990	(17,080)
Customer funds administered	(11,848)	4,109
Net cash (used in) provided by financing activities	(23,106)	15,141
NET INCREASE IN CASH AND CASH EQUIVALENTS	30,531	47,172
CASH AND CASH EQUIVALENTS—Beginning of the year	72,752	25,580
CASH AND CASH EQUIVALENTS—End of year	$ 103,283	$ 72,752
SUPPLEMENTAL CASH FLOW DISCLOSURE—Cash paid for income taxes	$ 16,949	$ 324

See notes to financial statements.

1. ORGANIZATIONAL STRUCTURE AND OPERATION

Organization—Arizona Physicians IPA, Inc. (the "Company" or "APIPA") was incorporated on September 19, 1995. The Company is a wholly owned, for-profit subsidiary of United HealthCare, Inc. ("UHC"), which is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a Minnesota corporation. UHS provides management services to managed care companies and is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UHG"). UHG is a publicly held company trading on the New York Stock Exchange.

Operation—The majority of the Company's premium revenues result from its contracts with the Arizona Health Care Cost Containment System ("AHCCCS"). Under these contracts the Company provides health care benefits to Medicaid enrollees ("Acute") and Children's Rehabilitative Services ("CRS") members. Effective January 1, 2014, under the Patient Protection and Affordable Care Act ("ACA") expansion, the Acute contract includes adult beneficiaries whose income does not exceed 138% of the federal poverty level. The contracts have been approved by AHCCCS and expire on September 30, 2016, with capitation rates up for renewal annually. The Company also contracts with the Arizona Department of Economic Security Division for Developmental Disabilities ("DES/DDD") and the Centers for Medicare and Medicaid Services ("CMS") for its Medicare Advantage health plan.

Effective October 1, 2014, the Company assumed all responsibilities on the Arizona Long Term Care System ("ALTCS") contract beginning with contract year 2015 from UnitedHealthcare Integrated Services, Inc. ("UHCIS"), formerly Evercare of Arizona, Inc., an affiliate. The eligible membership, which was previously enrolled on UHCIS, was enrolled in the Company as of the effective date. This transaction has been approved by AHCCCS on September 5, 2014. There was no consideration paid to UHCIS in the transaction, the ALTCS contract was transferred at the transferor's basis of zero, and no extraordinary gain or loss was recognized by the Company as a result of the transaction, as this was a transfer among subsidiaries under common control. The contract has a one year term and is subject to renewal on September 30, 2015.

2. BASIS OF PRESENTATION, USE OF ESTIMATES AND SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation—The Company has prepared the financial statements according to United States of America (U.S.) Generally Accepted Accounting Principles (GAAP).

Use of Estimates—These financial statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates are related to medical services expenses, AHCCCS reinsurance receivable, AHCCCS PCP enhanced rate payments receivable, medical services payable, Medicaid risk sharing payable, valuation of certain investments, and estimates and judgments related to income taxes. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain, and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Cash, Cash Equivalents, and Investments—Cash and cash equivalents are highly liquid investments with original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Cash and cash equivalents primarily represent the Company's share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments being less than 60 days. The Company's share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or amortized cost. Interest income from the pool accrues daily to participating members based upon ownership percentage.

The Company had checks outstanding of $1,518 and $8,766 at December 31, 2014 and 2013, respectively, which were classified in accounts payable and accrued expenses in the balance sheets. The change in this balance has been reflected as checks outstanding within financing activities in the statements of cash flows. The outstanding checks are related to zero balance accounts. The Company does not net checks outstanding with deposits in other accounts.

Investments with maturities of less than one year are classified as short-term. All other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from earnings, and reports them as other comprehensive income (loss) and, net of income tax effects, as a separate component of stockholder's equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer, and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends to either sell, or determines that it will be more likely than not required to sell a security before recovery of the entire amortized cost basis of maturity of the security, the Company recognizes the entire impairment in investment income. If the Company does not intend to sell the debt security, and it determines that it will not be more likely than not required to sell the security, but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income (loss).

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate obligations, substantially all of which are investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment receivables in the balance sheets. The Company evaluates the collectability of the amounts due and amounts determined to be uncollectible are written off in the period in which the determination is made.

Investment Income—net includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and certain external investment management costs are also included in investment income—net.

Revenues—Capitation and risk-sharing settlements and delivery supplemental premiums are contractual. Capitation revenues are generally paid in advance of the coverage period in which benefits are to be provided and are earned and recognized during the applicable coverage period regardless of whether services are incurred. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled.

Effective October 1, 2013, AHCCCS withholds 1% of gross prospective capitation from all contractors in Arizona to be redistributed based upon each contractor's performance on selected Quality Management Performance Measures as determined by AHCCCS. The Company accrued $3,743 and $1,619 as of December 31, 2014 and 2013, respectively, for withheld revenues it expects to collect for this program as premiums receivable in the balance sheets and capitation and risk-sharing settlements within the statements of operations.

CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk-adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS, which result in changes to its Medicare revenues. The Company recognizes such changes when the amounts become determinable and supportable and collectability is reasonably assured. The estimated risk adjusted payments due to the Company at December 31, 2014 and 2013, were $8,699 and $4,869 respectively, and are recorded as premiums receivable in the balance sheets. The Company recognized $8,679 and $563 for changes in prior year Medicare risk factor estimates during the years ended December 31, 2014 and 2013, respectively, which is recorded as capitation and risk-sharing settlements within the statements of operations.

AHCCCS also applies a risk adjustment using a national episodic/diagnostic risk adjustment model for the existing risk groups that spreads the rate adjustments within the impacted groups. The estimated risk adjustment payment due to the Company at December 31, 2014 and 2013 were $0 and $607, respectively, and are recorded as other contract program receivables in the balance sheets. The Company recognized $6,113 for changes in prior year Medicaid risk factor estimates during the year ended December 31, 2014 which is recorded as capitation and risk-sharing settlements within the statements of operations.

Delivery supplemental premium payments are per delivery and intended by AHCCCS to cover the cost of maternity care. Such premiums are recognized in the month that the delivery occurs. Total premiums of $48,548 and $47,135 for 2014 and 2013, respectively, are recorded in the delivery supplemental premiums in the statements of operations and receivables from contract programs in the accompanying balance sheets.

Effective October 1, 2014, the Company records revenues related to the ALTCS contract. Prospective capitation is paid for those members who are receiving long-term care services and reside in a nursing facility, a certified home and community based setting or in their own home. The prospective capitation rate is a blended rate that uses an institutional rate and a Home and Community Based Services ("HCBS") rate based on an assumed placement ratio of HCBS member months to total member months for each geographic service area. Additionally, the prospective capitation incorporates an assumed deduction for the Share of Cost ("SOC"), which members contribute to the cost of care based on their income and type of placement. The Company and its contracted providers collect members' SOC directly from members.

At the end of the contract year, AHCCCS compares the actual HCBS member months to the assumed HCBS percentage that was used to determine the full long-term care capitation rate for that year. If the Company's actual HCBS percentage is different than the assumed percentage, AHCCCS will recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months, which exceeded (or was less than) the assumed percentage. The Company recorded $514 related to HCBS redetermination as Medicaid risk sharing payable in the balance sheets at December 31, 2014.

After the end of the contract year, AHCCCS compares actual SOC assignment to the SOC assignment assumed in the calculation of the prospective capitation rate. Assumed SOC will be fully reconciled to actual SOC assignment, and AHCCCS will either recoup or refund the total difference, as applicable. The Company recorded $862 related to member SOC redetermination as premiums receivable in the balance sheets at December 31, 2014.

Medical Services Expenses and Medical Services Payables—Medical services expenses and medical services payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed, and for liabilities for physician, hospital and other medical cost disputes. The Company develops estimates for medical services expenses incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates liabilities for physician, hospital and other medical services payable disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, the Company re-examines previously established medical services payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical services payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical services expenses in the period in which the change is identified.

The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital and nursing home negotiated per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 9). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

The Company has agreements with certain medical providers that provide for the establishment of a pool into which the Company places funds based on the performance of the provider as defined in the contract. The Company manages the disbursement of funds from this account as well as reviews the utilization and designated quality scores based on members assigned to the provider. Any surpluses

and/or deficits in the pool are shared by the Company and the provider based upon specific contracts and the liability is included within medical services payable on the balance sheets.

AHCCCS Reinsurance—Reinsurance is a stop-loss program provided by AHCCCS for the partial reimbursement of covered medical services and those costs incurred beyond an annual deductible per member. AHCCCS provides regular reinsurance so long as the member incurred an inpatient stay, catastrophic reinsurance for those members receiving certain drugs or diagnosed with specific disorders, transplant reinsurance and other reinsurance. Claims containing any prior period coverage are excluded from reinsurance coverage. Recoveries from AHCCCS are recorded at estimated amounts due to the Company pursuant to the Acute, CRS, ALTCS and DES/DDD contracts. All contracts require the respective agencies to reimburse the Company 75% (85% for catastrophic cases for Acute, CRS and DES/DDD contracts) of qualified health care costs in excess of a recovery deductible. The deductibles applied are $50 for DES/DDD, $25 for Acute, and $75 for CRS. The deductible for members covered under the ALTCS contract is dependent upon the Company's enrollment. For cases where qualified medical out-of-pocket expense exceeds $650, the Company is reimbursed for 100% of the expense.

The Company estimated recoveries from AHCCCS in AHCCCS reinsurance receivables in the balance sheets as of December 31, 2014 and 2013, respectively. Recoveries from AHCCCS have been offset against medical services expenses in the statements of operations.

Medicare Part D Pharmacy Benefits—The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium*. CMS pays a fixed monthly premium per member to the Company for the entire plan year.

- *Member Premium*. Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.

- *Low-Income Premium Subsidy*. For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.

- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a monthly cost reimbursement estimate to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS, based on actual cost experience, after the end of the plan year.

- *Low-Income Member Cost Sharing Subsidy*. For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays for the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company, based on actual claims and premium experience, after the end of the plan year.

- *CMS Risk-Share*. Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company, or require the Company to refund to

CMS a portion of the premiums received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to capitation and risk-sharing settlements in the statements of operations and payables to contract programs or receivables from contract programs in the balance sheets.

- *Drug Discount.* Beginning in 2011, Health Reform Legislation mandated a consumer discount of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers, while the Company administers the application of these funds. Amounts received are not reflected as capitation and risk-sharing settlements, but rather are accounted for as deposits. The Company records a payable when amounts are received from CMS, and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as customer funds administered within financing activities in the statements of cash flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and are therefore recorded as capitation and risk-sharing settlements in the statements of operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in other payables to contract programs in the balance sheets.

The Company's Medicare Part D program business is subject to a retrospective rating feature related to Part D premiums. The Company has estimated accrued retrospective premiums related to certain Part D premiums based on guidelines determined by CMS. The formula is tiered and based on bid medical loss ratio. The amount of Part D premiums subject to retrospective rating was $36,162 and $33,155 for the years ended December 31, 2014 and 2013, respectively, representing 1.9% and 2.5% of total revenues excluding investment income as of December 31, 2014 and 2013, respectively.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy ("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. Amounts received for these Subsidies are not reflected as capitation and risk-sharing settlements but rather are accounted for as deposits, with related amounts recorded in other contract program receivables in the balance sheets. The Company recorded $15,363 and $3,516 in other contract program receivables as of December 31, 2014 and 2013, respectively, for cost reimbursements under the Medicare Part D program for the catastrophic reinsurance and low-income member cost sharing subsidies. Related cash flows are presented as customer funds administered within financing activities in the statements of cash flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred, and are recognized in medical services expenses and administrative expenses, respectively, in the statements of operations.

The Company has settlements with CMS based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare Part D program regional plan varies more than 5% above or below the level estimated in the original bid submitted by the Company and approved by CMS in 2014 and 2013. The estimated risk share adjustment of $25 and $(1,883) in 2014 and 2013, respectively, is recorded as other contract program receivables and other payables to contract programs in the balance

sheets and an increase (decrease) to capitation and risk-sharing settlements in the statements of operations. The final 2014 risk-share amount is expected to be settled during the second half of 2015 and is subject to the reconciliation process with CMS.

Total premium revenues from CMS related to the Medicare Part D program and all other Medicare-related programs were approximately 25.7% and 29.7% of capitation and risk-sharing settlements reported in the statements of operations for the years ended December 31, 2014 and 2013, respectively.

As of January 1, 2015, certain changes were made to the Medicare Part D coverage by CMS, including: (in whole dollars)

- The initial coverage limit increased to $2,960 from $2,850 in 2014.
- The catastrophic coverage begins at $6,680 as compared to $6,455 in 2014.
- The annual out-of-pocket maximum increased to $4,700 from $4,550 in 2014.
- The discounts on prescription drugs within the coverage gap increased to 55% from 52.5% in 2014 for brand name drugs and increased to 35% from 28% in 2014 for generic drugs.

Medicaid Risk Sharing—Due to the uncertainty regarding actual utilization and medical cost experience, AHCCCS limits the financial risk to the Company through risk share reconciliations. The Company has yearly risk-sharing agreements with AHCCCS for the Acute, CRS, and ALTCS members to cover medical expenses in excess of certain limits established by the contract. The reconciliation is tiered beginning at 3%, recouping different percentages of the excess in intervals up to profits of 6%. AHCCCS will repay all losses above 3%. For the prior period coverage, capitated Acute groups are evaluated on a risk band of 2% and ALTCS groups are evaluated on a risk band of 5%. Receivables or payables and the corresponding revenues or contra-revenues are recorded depending on the surplus or deficit of revenues over medical and certain administrative expenses for the period and are calculated in accordance with the contract.

The Company estimated Medicaid risk-sharing payables of $31,927 and $19,517 on the balance sheets as of December 31, 2014 and 2013 respectively, and risk-sharing receivables of $0 and $352 as other contract program receivables as of December 31, 2014 and 2013, respectively. The change in estimated risk share of $(18,929) and $7,444 in 2014 and 2013, respectively, is recorded as an (decrease) increase to capitation and risk-sharing settlements in the statements of operations. In 2013 the final reconciliation and settlement for the Acute contract year ending October 31, 2011 was received and the Company recorded a favorable change in the estimated risk share payables as recorded at December 31, 2012 of $10,261. The primary driver behind the favorable retroactivity is due to a change to clarification in the underlying administrative expense component within the Company's estimated calculation. The favorable retroactivity is included in capitation and risk-sharing settlements in the statements of operations for the year ended December 31, 2013. For the year ended December 31, 2014 there were no significant changes as a result of retroactivity.

Loss Adjustment Expenses—Loss adjustment expenses are costs that are expected to be incurred in connection with the adjustment and recording of health claims. Management believes the amount of the liability for unpaid claims adjustment expenses and associated claims interest as of December 31, 2014, is adequate to cover the Company's cost for the adjustment of unpaid claims; however, actual expenses may differ from those established estimates. It is the responsibility of UHS to pay loss adjustment expenses in the event the Company ceases operations. As of December 31, 2014 and 2013, the loss

adjustment expenses included in the accompanying balance sheets in the accounts payable and accrued expenses line item is $3,758 and $3,047, respectively.

Administration of AHCCCS Funds—The Company has three agreements with AHCCCS which became effective during 2013 to administer funds from AHCCCS to specific provider populations and are accounted for as deposits. The funds transferred are reported as AHCCCS funds administered under cash flows from financing on the statements of cash flows.

Primary Care Physician Enhancement Payments—Effective for calendar years 2013 and 2014 the ACA has mandated that certain physicians practicing primary care ("PCPs") are eligible to receive increased payments for specified primary care services provided to Medicaid eligible individuals. This is to encourage PCPs to serve the Medicaid population in advance of the Medicaid expansion in 2014.

The state has elected to administer the additional PCP funds through non-risk reconciled payments for enhanced rates model. Under this model, the state's capitation rate is not inclusive of the enhanced rate. The Company is reimbursed at agreed upon intervals for all of the enhanced payment amounts in the determined period. There is no risk to the Company because any excess or shortfall is 100% remitted or received back from the state. The Company recorded a receivable from AHCCCS in other contract program receivables of $10,090 and $17,408 in the balance sheets of as of December 31, 2014 and 2013, respectively.

Rural Hospital Enhancement Payments—Effective October 1, 2013, the Company entered into an agreement with AHCCCS in which it will pass through supplemental inpatient reimbursement payments to qualifying rural hospitals as determined by AHCCCS. AHCCCS remits payment and informs the Company of the amount to be paid to each provider. The Company then makes the prescribed payments to the providers specified within 15 days of the receipt of funds. There is no risk to the Company as a result of this program. At December 31, 2014 and 2013, the Company has nothing recorded on the balance sheets related to this program.

Premium Deficiency Reserve—The Company assesses the profitability of its contract for providing health care services to its members when current operating results or forecasts indicate possible future losses. The Company compares anticipated premiums to health care related costs, including estimated payments for physicians and hospitals, commissions, and costs of collecting premiums and processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. The Company has no amounts recorded for premium deficiency reserves as of December 31, 2014 and 2013.

Concentration of Business and Credit Risk—Future contract awards are contingent upon the continuation of the Acute, ALTCS, DES/DDD, and CRS programs by AHCCCS and the State of Arizona and the continuation of the CMS Medicare Advantage program and the Company's ability and desire to retain its status as a contractor under the programs. For the years ended December 31, 2014 and 2013, all of the Company's total revenues and receivables were from these programs.

Premiums from the Acute, Medicare and CRS contracts of $1,048,088, $472,270 and $206,005, respectively; represent 56%, 25% and 11% of total revenues excluding investment income for the year ended December 31, 2014. Premiums from the Acute and Medicare contracts of $751,273 and $381,723, respectively; represent 56% and 29% of total revenues excluding investment income for the year ended December 31, 2013. All other contracts represent less than 10% of total revenues excluding investment income.

Concentration of credit risk with respect to receivables is limited due to the fact that AHCCCS, DES/DDD, and CMS are governmental agencies.

Industry Tax—The ACA includes an annual, nondeductible insurance industry tax ("Industry Tax") to be levied proportionally across the insurance industry for risk-based health insurance products that began on January 1, 2014.

The Company estimates its liability for the Industry Tax based on a ratio of the Company's applicable net premiums written, compared to the U.S. health insurance industry total applicable net premiums, for the previous calendar year. The Company records in full the estimated liability for the Industry Tax at the beginning of the calendar year, with a corresponding deferred cost that is amortized to administrative expenses in the statements of operations using a straight-line method of allocation over the calendar year. In September 2014, the Company paid its 2014 Industry Tax liability of $19,481.

AHCCCS has agreed to increase the capitation payments to the Company in response to the Industry Tax, including the nondeductible tax effect, for up to the amounts paid in 2014. The Company recorded $23,295 in related capitation and risk-sharing settlements in the statements of operations.

Recently Adopted Accounting Standards—In May 2014, the Financial Accounting Standards Board issued Accounting Standard Update (ASU) No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" (ASU 2014-09). 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 provides 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 may adopt the new standard using either the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

The Company has determined that there have been no other recently adopted or issued accounting standards that had or will have a material impact on its financial statements.

Reclassifications—Certain 2013 amounts in the financial statements have been reclassified to conform to the 2014 presentation. The change in presentation is to provide additional information on the composition of the Company's receivables, payables, and medical services expense. There have been no changes to total assets, liabilities, total stockholders' equity, total medical services expenses or net income as a result of the change in presentation.

3. PLEDGES/ASSIGNMENTS AND GUARANTEES

The Company has no pledges, assignments, collateralized assets, or guaranteed liabilities not disclosed in the balance sheets as of December 31, 2014 and 2013.

4. PERFORMANCE BONDS

Pursuant to its contracts with AHCCCS, DES/DDD, and CMS, the Company is required annually to provide performance bonds, in an acceptable form, to guarantee performance of the Company's obligations under certain contracts. To satisfy this requirement, the Company maintained surety bonds in 2014 and 2013 in the amounts of $177,100 and $121,714, respectively, which are included in long-term investments in the balance sheets. The bonds are unsecured and require no Company assets to secure the obligations.

5. MEDICAL SERVICES PAYABLE ANALYSIS

Changes in estimates related to prior years' incurred claims are included in medical services expenses in the current year in the statements of operations. Stop loss recoveries are included in receivables from contract programs in the accompanying balance sheets and claim overpayment receivables are included in other receivables in the accompanying balance sheets. The following tables disclose paid claims, incurred claims, and the balance in the unpaid claim reserve for the years ended December 31, 2014 and 2013:

	2014		
	Current Year Incurred Claims	Prior Years' Incurred Claims	Total
Beginning year medical services payable	$ -	$ (170,360)	$ (170,360)
Paid claims—net of stop loss recoveries, pharmacy rebates and claim overpayments collected	1,470,458	158,243	1,628,701
End of year medical services payable	228,249	2,628	230,877
Incurred claims excluding stop loss recoveries, pharmacy rebate and claim overpayment receivables as presented below	1,698,707	(9,489)	1,689,218
Beginning stop loss recoveries, pharmacy rebate and claim overpayment receivables	-	29,882	29,882
End of year stop loss recoveries, pharmacy rebate and claim overpayment receivables	(44,903)	(6,637)	(51,540)
Total incurred claims	$ 1,653,804	$ 13,756	$ 1,667,560

	2013		
	Current Year Incurred Claims	Prior Years' Incurred Claims	Total
Beginning year medical services payable	$ -	$ (147,002)	$ (147,002)
Paid claims—net of stop loss recoveries, pharmacy rebates and claim overpayments collected	1,028,604	98,443	1,127,047
End of year medical services payable	165,967	4,393	170,360
Incurred claims excluding stop loss recoveries, pharmacy rebate and claim overpayment receivables as presented below	1,194,571	(44,166)	1,150,405
Beginning stop loss recoveries, pharmacy rebate and claim overpayment receivables	-	34,834	34,834
End of year stop loss recoveries, pharmacy rebate and claim overpayment receivables	(28,335)	(1,547)	(29,882)
Total incurred claims	$ 1,166,236	$ (10,879)	$ 1,155,357

The liability for medical services payable, net of stop loss recoveries and claim overpayment receivables, as of December 31, 2013 was $140,478. As of December 31, 2014, $158,243 has been paid for incurred claims attributable to insured events of prior years. The medical services payable remaining for prior years including the effect of stop loss recoveries and claim overpayment receivables are now $(4,009) as a result of re-estimation of unpaid claims. Therefore, there has been $13,756 of unfavorable prior year development since December 31, 2013 to December 31, 2014. The primary drivers consist of unfavorable development of $19,093 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, $984 in risk share, and $899 in provider settlements. This was partially offset by favorable development of $7,790 as a result of a change in the provision for adverse deviations in experience. At December 31, 2013, the Company recorded $10,879 of favorable development primarily driven by $7,261 as a result of a change in the provision for adverse deviations in experience and by $3,615 of favorable development in retroactivity for inpatient, outpatient, physician, vision, dental, and pharmacy claims. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

6. CONTINGENT LIABILITIES AND GOVERNMENT REGULATIONS

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the accompanying balance sheets or statements of operations of the Company.

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

Risk Adjustment Data Validation (RADV) Audit—CMS adjusts capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

CMS and the Office of Inspector General for Health and Human Services periodically perform RADV audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to the Company, fines, corrective action plans or other adverse action by CMS.

In February 2012, CMS announced a final RADV audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

Health Reform Legislation and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's results of operations, financial condition and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

7. INVESTMENTS

A summary of investments by major security type is as follows:

December 31, 2014	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities—available-for-sale:				
U.S. government and agency obligations	$ 15,066	$ 14	$ (46)	$ 15,034
State and municipal obligations	90,598	4,671	(31)	95,238
Corporate obligations	46,618	431	(174)	46,875
U.S. agency mortgage-backed securities	23,997	369	(1)	24,365
Non-U.S. agency mortgage-backed securities	10,959	148	(35)	11,072
Total debt securities—available-for-sale	187,238	5,633	(287)	192,584
Total investments	$187,238	$5,633	$ (287)	$192,584
December 31, 2013				
Debt securities—available-for-sale:				
U.S. government and agency obligations	$ 15,042	$ -	$ (280)	$ 14,762
State and municipal obligations	84,748	2,928	(791)	86,885
Corporate obligations	46,727	638	(287)	47,078
U.S. agency mortgage-backed securities	23,783	139	(649)	23,273
Non-U.S. agency mortgage-backed securities	9,053	268	(113)	9,208
Total debt securities—available-for-sale	179,353	3,973	(2,120)	181,206
Total investments	$179,353	$3,973	$ (2,120)	$181,206

The fair value of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination as of December 31, 2014, were as follows:

	AAA	Non-Investment Grade	Total Fair Value
2014	$ 2,985	$ -	$ 2,985
2013	1,217	-	1,217
2012	1,306	-	1,306
2011	498	-	498
2009	787	-	787
Pre–2009	4,279	-	4,279
U.S. agency mortgage-backed securities	24,365	-	24,365
Total	$ 35,437	$ -	$ 35,437

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2014, by contractual maturity, were as follows:

	2014	
	Amortized Cost	Fair Value
Due in one year or less	$ 6,824	$ 6,913
Due after one year through five years	52,021	53,393
Due after five years through ten years	60,248	63,159
Due after ten years	33,189	33,682
U.S. agency mortgage-backed securities	23,997	24,365
Non-U.S. agency mortgage-backed securities	10,959	11,072
Total debt securities—available-for-sale	$ 187,238	$ 192,584

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less than 12 Months		12 Months or Greater		Total	
December 31, 2014	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
Debt securities—available-for-sale:						
U.S. government and agency obligations	$ 7,381	$ (46)	$ -	$ -	$ 7,381	$ (46)
State and municipal obligations	4,022	(19)	1,136	(11)	5,158	(30)
Corporate obligations	17,509	(100)	4,322	(74)	21,831	(174)
U.S agency mortgage-backed securities	491	(1)	-	-	491	(1)
U.S. non-agency mortgage-backed securities	2,765	(20)	986	(16)	3,751	(36)
Total debt securities—available-for-sale	$32,168	$ (186)	$6,444	$(101)	$38,612	$ (287)
December 31, 2013						
Debt securities—available-for-sale:						
U.S. government and agency obligations	$14,512	$ (253)	$ 250	$ (27)	$14,762	$ (280)
State and municipal obligations	23,069	(678)	2,106	(113)	25,175	(791)
Corporate obligations	18,986	(287)	-	-	18,986	(287)
U.S agency mortgage-backed securities	18,745	(649)	-	-	18,745	(649)
U.S. non-agency mortgage-backed securities	2,564	(62)	1,617	(51)	4,181	(113)
Total debt securities—available-for-sale	$77,876	$(1,929)	$3,973	$(191)	$81,849	$(2,120)

The unrealized losses from all securities as of December 31, 2014, were generated from approximately 70 positions out of a total of approximately 290 positions. The Company believes that it will collect all principal and interest due on its investments that have an amortized cost in excess of fair value. The unrealized losses on investments were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its amortized cost. The contractual cash flows of the U.S. government and agency obligations are either guaranteed by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting whether a significant deterioration since purchase or other factors that may indicate an other-than temporary impairment ("OTTI"), such as the length of time and extent to which fair value has been less than cost, the financial condition, and near term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. As of December 31, 2014, the Company did not have the intent to sell any of the securities in an unrealized loss position.

Net realized gains included in investment income on the statements of operations were from the following sources:

	Years Ended December 31,	
	2014	2013
Total OTTI	$ -	$ -
Net OTTI recognized in earnings	-	-
Gross realized losses from sales	(429)	(85)
Gross realized gains from sales	1,324	1,031
Net realized gains (included in investment income—net on the statements of operations)	895	946
Income tax effect (included in provision for income taxes on the statement of operations)	(348)	(371)
Realized gains, net of taxes	$ 547	$ 575

8. FAIR VALUE

Certain assets and liabilities are measured at fair value in the consolidated financial statements, or have fair values disclosed in the notes to financial statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1—Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in non active markets (e.g., few transactions, limited information, non current prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3—Unobservable inputs that cannot be corroborated by observable market data.

Non-financial assets and liabilities, or financial assets and liabilities that are measured at fair value on a nonrecurring basis, are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2014 and 2013.

The following table presents a summary of the fair value measurements by level for assets and liabilities measured at fair value on a recurring basis:

December 31, 2014	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
Cash and cash equivalents	$103,283	$ -	$ -	$103,283
Debt securities—available-for-sale:				
U.S. government and agency obligations	15,034	-	-	15,034
State and municipal obligations	-	95,238	-	95,238
Corporate obligations	-	46,875	-	46,875
U.S. agency mortgage-backed securities	-	24,365	-	24,365
Non-U.S. agency mortgage-backed securities	-	11,072	-	11,072
Total debt securities—available-for-sale	15,034	177,550	-	192,584
Total cash, cash equivalents, and investments at fair value	$118,317	$177,550	$ -	$295,867
December 31, 2013				
Cash and cash equivalents	$ 72,752	$ -	$ -	$ 72,752
Debt securities—available-for-sale:				
U.S. government and agency obligations	14,762	-	-	14,762
State and municipal obligations	-	86,885	-	86,885
Corporate obligations	-	47,078	-	47,078
U.S. agency mortgage-backed securities	-	23,273	-	23,273
Non-U.S. agency mortgage-backed securities	-	9,208	-	9,208
Total debt securities—available-for-sale	14,762	166,444	-	181,206
Total cash, cash equivalents, and investments at fair value	$ 87,514	$166,444	$ -	$253,958

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2014 or 2013.

The Company does not have financial assets with a fair value hierarchy of Level 3.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument:

Cash and Cash Equivalents—The carrying value of cash and cash equivalents approximates fair value, as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities—Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security, primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes.

As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source such as its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures, and review of fair value methodology documentation provided by independent pricing services, have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets, but are priced using other observable inputs, are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity security and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The carrying amounts reported in the balance sheets for other receivables and accounts payable and accrued expenses approximate fair value because of their short-term nature.

9. RELATED-PARTY TRANSACTIONS

Pursuant to the terms of a Management Agreement (the "Agreement"), UHS will provide management services to the Company under a fee structure, which is based on a percentage of premium charge representing UHS' expenses for services or use of assets provided to the Company. In addition, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a PMPM basis (where the charge incurred by UHS is on a PMPM basis) or using another allocation methodology consistent with the Agreement. These services may include, but are not limited to, integrated personal health management solutions, such as disease management and treatment decision support, including a 24-hour call-in service, access to a network of transplant providers, and discount program services. The amount and types of services provided pursuant to the pass-through provision of the Agreement can change year over year as UHS becomes the contracting entity for services provided to the Company's members. Total administrative services, capitation, and access fees under this arrangement totaled $137,071 and $124,174 in 2014 and 2013, respectively, and are included in medical services expenses and administrative expenses in the statements of operations. Direct expenses not covered under the Agreement, such as broker commissions, ACA assessments, and premium taxes, are paid by UHS on behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

The Company also directly contracts with related parties to provide services to its members. The Company expensed as medical services expenses and administrative expenses $7,295 and $11,216 in capitation fees and administrative services to related parties during 2014 and 2013, respectively. OptumHealth Care Solutions, Inc. provides chiropractic, speech therapy, physical therapy and occupational therapy services. Dental Benefit Providers, Inc. provides dental care assistance. United Behavioral Health provides mental health and substance abuse services. The Company entered into a new agreement with INSPIRIS, Inc. effective January 1, 2013 to provide health home assessments. INSPIRIS services were replaced by home-health services coordinated through UHS in 2014.

The capitation expenses, administrative services, and access fees paid to related parties, that are included as medical services expenses and administrative expenses in the accompanying statements of operations for the years ended December 31, 2014 and 2013, are shown below:

	2014	2013
Dental Benefit Providers, Inc.	$ 4,492	$ 8,880
United Behavioral Health	2,326	917
INSPIRIS, Inc.	-	1,026
OptumHealth Care Solutions, Inc.	477	393
Total	$ 7,295	$ 11,216

The Company contracts with OptumRx, Inc. to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees. Fees related to these agreements, which are calculated on a per-claim basis, of $8,675 and $6,102 in 2014 and 2013, respectively, are included in administrative expenses in the accompanying statements of operations. Additionally, OptumRx collects rebates on certain pharmaceutical products based on member utilization. Rebate receivables of $17,443 and $10,029 as of December 31, 2014 and 2013, respectively, are included as related-party receivable—net on the balance sheets.

The Company contracts with OptumRx, Inc. to provide personal health products catalogues showing the health care products and benefit credits needed to redeem the respective products. OptumRx, Inc. will mail the appropriate personal health products catalogues to the Company's members and manage the personal health products credit balance. OptumRx, Inc. also distributes personal health products to individual members based upon the terms of the agreement. Fees related to this agreement in 2014 and 2013, which are calculated on a PMPM basis, of $6,812 and $5,847 are included in the other medical services expenses in the accompanying statements of operations.

The Company holds a $50,000 subordinated revolving credit agreement with UHG, at an interest rate of London InterBank Offered Rate, plus a margin of 0.50%. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. No amounts were outstanding under the line of credit as of December 31, 2014 and 2013.

The remaining related-party receivable—net, as reflected in the accompanying balance sheets, represents costs incurred in the ordinary course of business by, or on behalf of, the Company.

10. STOCKHOLDER'S EQUITY

As a result of the change in net unrealized gains and losses on investments available-for-sale, the Company had accumulated other comprehensive income of $3,267 and $1,126 as of December 31, 2014 and 2013, respectively.

The Company received an infusion of $12,000 on January 11, 2013 and an infusion of $15,000 on March 28, 2013 from its parent, UHC. This was recorded as an increase to additional paid-in capital.

The Company returned stockholder's equity of $25,000 on March 21, 2014 to UHS. This was recorded as a decrease to additional paid-in capital and retained earnings. The stockholder's equity associated with AHCCCS contracts was not decreased as a result of the dividend, therefore, no approval was required prior to distribution.

The Company received an infusion of $14,000 on September, 19, 2014 from UHS. This was recorded as an increase to additional paid-in capital.

On February 20, 2013 all previously held common stock was canceled and two shares of $0.01 par value common stock were issued to UHC.

11. COMPLIANCE WITH FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES

For the contract year ended September 30, 2014, the Company was not in compliance with the equity per member requirement for its Acute members. This deficiency was remediated prior to December 31, 2014. The Company was in compliance with all other Financial Viability Standards and Performance Guidelines at the end of the contract year. Performance against these standards and guidelines for the contract year ending September 30, 2015 is being monitored by the Company on a quarterly basis.

12. DRUG REBATES/DISCOUNTS

The Company received and accrued $33,080 and $20,911 in pharmacy rebates in 2014 and 2013, respectively. The pharmacy rebates are included as a reduction in other medical services in the statements of operations (see Note 9).

13. INTEREST ON LATE CLAIMS

The Company paid $115 and $25 in interest on late claims for all members in 2014 and 2013, respectively. The interest on late claims is included in hospital inpatient services in the statements of operations.

14. ACCRUED SANCTIONS

The Company had accrued a liability of $808 and $604 for AHCCCS sanctions as of December 31, 2014 and 2013, respectively. The sanctions are included in accounts payable and accrued expenses in the accompanying balance sheets.

15. PROVIDER INCENTIVES

The Company does not currently offer any provider incentives.

16. NON-COVERED SERVICES

The Company performed a review of claims with dates of service in 2014. Areas of focus included non-covered outpatient rehabilitation services, chiropractic services and dental services for adults. Small amounts of services were identified as having been provided to adults for outpatient rehabilitation

services and chiropractic services. The results showed that $3 of chiropractic services and $10 of physical therapy services were paid for in 2014 for all members under contract.

17. INCOME TAXES

The Company's operations are included in the consolidated federal income tax return of UHG. Federal and state income taxes are paid to or refunded by UHG pursuant to the terms of a tax sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis. The Company receives a benefit at the federal rate in the current year for net losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UHG. There were no net operating losses or other tax carry forwards as of December 31, 2014 or 2013.

The components of the provision for income taxes for the years ended December 31, are as follows:

	2014	2013
Current provision:		
Federal	$ 14,553	$ 7,432
State and local	3,031	1,728
Total current provision	17,584	9,160
Deferred provision:		
Federal	(238)	902
State and local	(34)	202
Total deferred provision	(272)	1,104
Total provision for income taxes	$ 17,312	$ 10,264

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes and the effective tax rate for the years ended December 31, 2014 and 2013 is as follows:

	2014		2013	
Tax provision at the U.S. federal statutory rate	$ 9,280	35.0 %	$ 9,738	35.0 %
Industry tax	6,818	25.7	-	-
State income taxes—net of federal benefit	1,948	7.4	1,254	4.5
Tax-exempt investment income	(787)	(3.0)	(781)	(2.8)
Other—net	53	-	53	-
Provision for income taxes	$ 17,312	65.10 %	$ 10,264	36.70 %

Current federal and state income taxes payable is $9,168 and $8,533 as of December 31, 2014 and 2013, respectively.

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities, based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year. The current income tax provision reflects the tax consequence of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

The components of deferred income tax assets and liabilities as of December 31, 2014 and 2013 are as follows:

	2014	2013
Deferred income tax assets:		
Bad debt reserve	$ 220	$ 170
Unpaid losses and loss adjustment expense	805	639
Total deferred income tax assets	1,025	809
Deferred income tax liabilities:		
Prepaid expenses	-	(64)
Investments	(62)	(56)
Unrealized gain	(2,080)	(727)
Total deferred income tax liabilities	(2,142)	(847)
Net deferred income tax liabilities	$ (1,117)	$ (38)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. There were no valuation allowances as of December 31, 2014 or 2013.

UHG currently files income tax returns in the United States federal jurisdiction, various states, and foreign jurisdictions. The U.S. Internal Revenue Service ("IRS") has completed exams on UHG's consolidated income tax returns for fiscal years 2013 and prior. UHG's 2014 tax return is under advance review by the IRS under its Compliance Assurance Program ("CAP"). With the exception of a few states, UHG is no longer subject to income tax examinations prior to 2007 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

The Company has not included a reconciliation of the beginning and ending amount of unrecognized tax benefits as it does not have any uncertain tax positions as of December 31, 2014 or 2013.

Federal and state income taxes paid, net of refunds, in 2014 was $16,949, and federal and state income taxes paid, net of refunds, in 2013 was $324.

18. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES, AND OTHER POSTRETIREMENT BENEFIT PLANS

The Company has no retirement plan, deferred compensation, and other benefit plans, since all personnel are employees of UHS, which provides services to the Company under the terms of a management agreement (see Note 9).

19. SUBSEQUENT EVENTS

In preparing these financial statements, management has evaluated and disclosed all material subsequent events up to April 29, 2015, the date that the draft financial statements were available to be issued.

There are no events subsequent to December 31, 2014, that require disclosure.

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EXHIBIT I—SUPPLEMENTAL COMBINING STATEMENTS (UNAUDITED)

ARIZONA PHYSICIANS IPA, INC.

SUPPLEMENTAL COMBINING BALANCE SHEETS
AS OF DECEMBER 31, 2014 (UNAUDITED)
(In thousands)

ASSETS	Acute	DD	CRS	Medicare	LTC	Eliminations	Total
CURRENT ASSETS:							
Cash and cash equivalents	$103,283	$ -	$ -	$ -	$ -	$ -	$103,283
Short-term investments	6,913	-	-	-	-	-	6,913
Premiums receivable	16,690	1,815	1,288	9,130	804	-	29,727
AHCCCS reinsurance receivable	16,282	2,198	7,191	-	2,726	-	28,397
AHCCCS PCP enhanced rate payments receivable	7,322	1,753	1,004	-	11	-	10,090
Other contract programs receivable	-	-	-	15,389	-	-	15,389
Other receivables—net of allowances of $566	2,869	49	119	2,312	350	-	5,699
Related-party—net	3,869	-	-	-	-	-	3,869
Due from other lines of business	-	11,685	34,802	56,844	48,162	(151,493)	-
Investment receivables	1,519	-	-	-	-	-	1,519
Current deferred taxes—net	928	-	-	-	-	-	928
Total current assets	159,675	17,500	44,404	83,675	52,053	(151,493)	205,814
LONG-TERM INVESTMENTS	185,671	-	-	-	-	-	185,671
TOTAL	$345,346	$17,500	$44,404	$83,675	$52,053	$(151,493)	$391,485
LIABILITIES AND STOCKHOLDER'S EQUITY							
CURRENT LIABILITIES:							
Medical services payable	$101,155	$ 5,611	$33,013	$59,795	$31,303	$ -	$230,877
Medicaid risk sharing payable	28,273	-	3,655	-	514	-	32,442
Accounts payable and accrued expenses	5,208	184	782	930	433	-	7,537
Due from other lines of business	151,493	-	-	-	-	(151,493)	-
Current income taxes payable	9,168	-	-	-	-	-	9,168
Total current liabilities	295,297	5,795	37,450	60,725	32,250	(151,493)	280,024
LONG-TERM DEFERRED INCOME TAXES—Net	2,045	-	-	-	-	-	2,045
Total liabilities	297,342	5,795	37,450	60,725	32,250	(151,493)	282,069
STOCKHOLDER'S EQUITY:							
Common stock, $0.01 par value—1,000,000 share authorized; two shares issued and outstanding	-	-	-	-	-	-	-
Additional paid-in capital	56,411	7,105	-	-	14,000	-	77,516
Retained earnings	(11,674)	4,600	6,954	22,950	5,803	-	28,633
Accumulated other comprehensive income	3,267	-	-	-	-	-	3,267
Total stockholder's equity	48,004	11,705	6,954	22,950	19,803	-	109,416
TOTAL	$345,346	$17,500	$44,404	$83,675	$52,053	$(151,493)	$391,485

ARIZONA PHYSICIANS IPA, INC.

SUPPLEMENTAL COMBINING STATEMENTS OF OPERATIONS
AS OF DECEMBER 31, 2014 (UNAUDITED)
(in thousands)

	Acute	DD	CRS	Medicare	LTC	Total
REVENUES:						
Capitation and risk-sharing settlements	$ 999,538	$77,657	$206,005	$472,270	$83,122	$1,838,592
Delivery supplemental premium	48,548	-	-	-	-	48,548
Investment Income	5,869	-	-	-	-	5,869
Total revenues	1,053,955	77,657	206,005	472,270	83,122	1,893,009
MEDICAL SERVICES EXPENSES:						
Hospital inpatient services	183,712	10,263	46,316	139,082	3,889	383,262
Medical compensation	295,720	12,707	83,400	88,346	2,396	482,569
Pharmacy	140,279	15,727	44,346	29,256	2,677	232,285
Outpatient facility	81,833	4,455	3,720	30,292	(383)	119,917
Emergency facility services	74,277	2,719	5,661	18,225	108	100,990
Nursing facility and home health care	39,065	8,851	787	32,599	5,439	86,741
Lab, x-ray, and medical imaging	37,491	927	2,016	20,582	508	61,524
Transportation	39,115	2,209	3,122	8,102	1,981	54,529
Dental	33,913	1,342	5,056	7,734	4	48,049
Other medical services	21,496	519	8,338	15,222	1,461	47,036
Durable medical equipment	11,566	10,322	11,332	8,532	1,053	42,805
Long-term care institutional	-	-	-	-	30,203	30,203
Long-term care home-based and community-based services	-	-	-	-	26,369	26,369
Recoveries from AHCCCS	(25,460)	(2,835)	(17,659)	-	(2,765)	(48,719)
Total medical services expenses	933,007	67,206	196,435	397,972	72,940	1,667,560
ADMINISTRATIVE EXPENSES	90,598	6,800	16,859	48,167	8,781	171,205
PREMIUM TAXES	21,539	-	4,473	-	1,717	27,729
Total expenses	1,045,144	74,006	217,767	446,139	83,438	1,866,494
INCOME (LOSS) BEFORE INCOME TAXES	8,811	3,651	(11,762)	26,131	(316)	26,515
PROVISION (BENEFIT) FOR INCOME TAXES	7,389	1,780	(3,695)	11,957	(119)	17,312
NET INCOME (LOSS)	$ 1,422	$ 1,871	$ (8,067)	$ 14,174	$ (197)	$ 9,203