CENTENE® Corporation

# Reaching for the Summit >>>

2004 Annual Report

# Four Years of Growth

**Centene is a *multi-line* managed care organization that provides Medicaid and Medicaid-related programs to organizations and individuals through government-subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). In addition, we provide specialty services including behavioral health, nurse triage and treatment compliance to our own and other healthcare organizations. We have health plans in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin. We also provide specialty services in each of the states where we have health plans as well as free-standing programs in Arizona, California and Colorado.**

## 2001

▲ Centene acquired the Medicaid business from Humana in both Wisconsin and Texas.

▲ Centene obtained a service area expansion for Austin and San Antonio and opened offices in both locations.

▲ Centene filed its registration statement with the U.S. Securities and Exchange Commission and became a publicly traded company on the NASDAQ National Market under the symbol CNTE.

## 2002

▲ Centene acquired a controlling interest in University Health Plans, Inc., adding 53,000 Medicaid members in 15 of 21 counties in New Jersey.

▲ Centene expanded its operations in Texas by acquiring Texas Universities Health Plans, allowing it to provide SCHIP services to more than 24,000 children in El Paso, Lubbock, Amarillo and San Antonio.

▲ The state of Texas asked Centene to provide managed care services for 28,000 members in Austin when two other health plans exited the state's Medicaid program.

▲ Centene acquired Bankers Reserve Life Insurance Company of Wisconsin.

## 2003

▲ Centene purchased the remaining interest of University Health Plans, Inc., and expanded to serve 20 counties throughout New Jersey.

▲ Centene acquired Group Practice Affiliates, a behavioral healthcare services company, serving more than 700,000 individuals.

▲ Centene acquired the assets of *Script*Assist, a treatment adherence program that uses registered nurses to counsel and motivate patients.

▲ Centene acquired the Medicaid-related assets of HMO Blue Texas in the San Antonio market, adding 17,000 Medicaid members.

▲ Centene began trading on the New York Stock Exchange under the symbol CNC.

## 2004

▲ Centene acquired the Medicaid-related assets of Family Health Plan in Toledo, Ohio, adding approximately 24,000 new Medicaid participants. Effective January 1, the Company began operations in Ohio as Buckeye Community Health Plan, Inc., a wholly-owned subsidiary.

▲ Centene established the Centene Foundation for Quality Health Care.

▲ Centene acquired two health plan entities, collectively known as FirstGuard, serving 135,000 members in Kansas and Missouri.

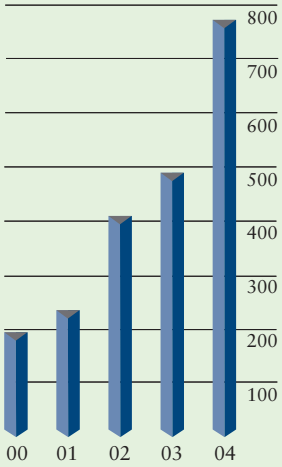
▲ Centene was awarded an Exclusive Provider Organization SCHIP contract to manage approximately 85,000 members in Texas.

▲ Centene realigned its Specialty Companies into a subsidiary company called CenCorp Health Solutions™, a *multi-line*, Medicaid focused specialty platform.

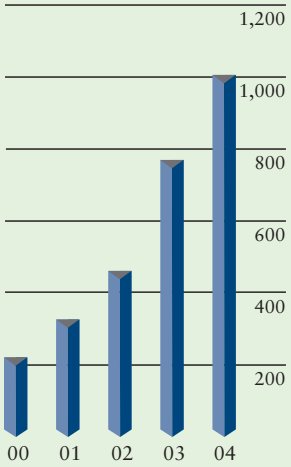
# Financial Highlights

| *(in thousands)* | 2004 | 2003 | December 31, 2002 | 2001 | 2000 |
|---|---|---|---|---|---|
| Total revenues | $1,000,940 | $769,730 | $461,487 | $326,569 | $221,350 |
| Earnings from operations | 64,536 | 46,927 | 31,606 | 18,472 | 6,520 |
| Net earnings | 44,312 | 33,270 | 25,621 | 12,428 | 7,236 |
| Total assets | 527,934 | 362,692 | 210,327 | 131,366 | 66,017 |

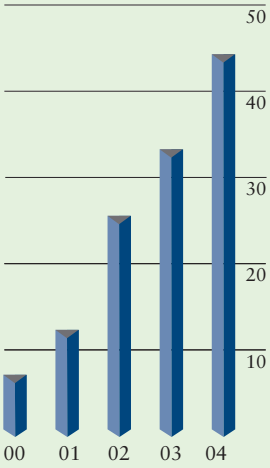
**Membership Growth**
*in thousands*



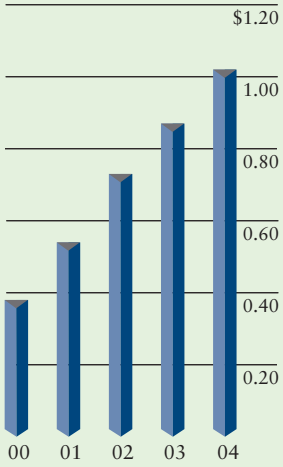

**Revenues**
*$ in millions*




**Net Earnings**
*$ in millions*




**Diluted Earnings Per Share**



# Letter to Stockholders

**Dear Stockholders,**

The year 2004 is most notable as the one in which we began to evolve from a collection of health plan and specialty companies into a true managed care *enterprise*. A sustainable enterprise has the attributes of growth, scale, discernable core competencies and diversity in product line. It is also the year in which we reached our first $1 billion in annual revenue and completed our twenty-second quarter of consecutive earnings growth. These financial milestones are important steps in our efforts towards *Reaching for the Summit*℠. We use this metaphor to describe our dual goal of striving for excellence in offering quality healthcare to our members while building a leading *multi-line* managed care organization. More importantly, it also describes the dedication and passion that compel and drive our employees, whose hard work is reflected in our many accomplishments to date.

In 2004, our financial and operational results were strong. Revenues for the year ended December 31, 2004, increased 30.0% to $1 billion, and earnings per share increased 17.2% to $1.02, as adjusted for our 2:1 stock split, which was effective in December. Operating cash flow reached $99.4 million, a 77.5% increase, and our balance sheet is healthy with $317.4 million in cash and investments. During 2004, we obtained a new $100 million credit facility, $34 million of which was outstanding at year-end, and filed a $300 million universal shelf registration statement to provide funds for future expansion.

Membership increased 57.8% over 2003, of which 25.3% was organic – further evidence of our states' commitment to managed care. The state of Indiana converted six new counties to Medicaid-mandated status in 2004 and has indicated that it will convert another five to seven in 2005. Additionally, we were awarded an Exclusive Provider Organization contract in the state of Texas to manage approximately 85,000 SCHIP members in 170 predominantly rural counties. In Ohio, which we entered in early 2004, we built solid relationships with providers and regulators as a foundation for future expansion.

We also capitalized on acquisition opportunities with the purchase of two health plan entities known collectively as FirstGuard, which added approximately 135,000 members. This transaction marked our entry into two additional Medicaid managed care states, Kansas and our home state of Missouri. With a combined 1.2 million eligible members and an opportunity to serve 160,000 SSI members, there is ample opportunity for organic growth in these two states.

Over the last several years, we have articulated our strategy to become a *multi-line* company that offers both core Medicaid and specialty services. To that end, we realigned our specialty companies under CenCorp Health Solutions (CenCorp), a subsidiary platform initially focused on behavioral health, nurse triage and treatment compliance. Our strategy was to put in place an arms length relationship between our core business and specialty companies, allowing us to sell these products and services to our health plans as well as other healthcare providers. We also wanted to ensure that third parties would have full confidence in the ability of our specialty companies to meet their specific needs. Today, we have in place the management expertise necessary to establish a solid platform for growth.

The progress of our specialty companies also continued in 2004 with a contract to manage behavioral health services for 34,000 SCHIP members in Kansas, which commenced in early 2005. Our Ohio subsidiary, Buckeye Community Health Plan, is working with the Ohio Department of Job and Family Services to serve approximately 1,900 enhanced case management members. These tactical moves are vital to our overall strategic and methodical approach to broaden our suite of services and provide a solid foundation upon which to build CenCorp.

There has been ongoing press concerning potential changes to or reform of the Medicaid system at both the state and federal levels. While we have long been a proponent of such change, we believe that many of these proposals still have a long way to play out. Moreover, we do not believe these potential changes will affect our ability to provide requisite services or programs. We recognize that the fiscal landscape is difficult, and there will be budget cuts, yet these circumstances promote better public policy and may even foster a more constructive environment in which to partner with the states. Ultimately, we believe that industry leaders who act together on public policy and who are responsible will create opportunities for viable markets and expand eligibility.

Despite budget challenges, Medicaid managed care is a growing category with expenditures having reached approximately $310 billion in 2004. As a result, companies like Centene fulfill a critical need. Today, we serve 772,700 members in seven states in the Temporary Assistance for Needy Families (TANF), State Children's Health Insurance Program (SCHIP) and Supplemental Security Income (SSI) populations.

**"The year 2004 is most notable as the one in which we began to evolve from a collection of health plan and specialty companies into a true managed care *enterprise*."**

In fact, we have developed recognized capabilities to manage the SSI population. To that end, we are allocating substantial financial and management resources for two principal reasons. First, there is a real opportunity to provide care to those who need it most. Second, we believe that we can offer states the ability to bring these same patients into managed care programs instead of the more inefficient and expensive

**Michael F. Neidorff**
**Chairman and**
**Chief Executive Officer**

fee-for-service alternative. The national expenditure for the SSI population is $58 billion with $14 billion of that total accounted for by the seven states in which we operate. Approximately 40% of these costs are related to behavioral issues, an area where we can be particularly effective through our specialty companies. In 2005, we will continue to work with each of our states to demonstrate the benefits of bringing in more SSI eligibles. We are confident that this will promote better health outcomes for members, while generating significant savings for the states.

Centene is also strengthening its infrastructure in other ways. We have broken ground on a 50,000-square-foot claims processing facility in Great Falls, Montana. When completed, this facility will be fully integrated with Centene's existing processing platform, enabling employees in different locations to manage data simultaneously. We are partnering with the state of Montana and are pleased with their commitment to provide Centene the opportunity to establish ourselves in Great Falls.

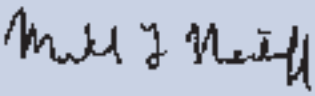
We also place great value in our strong provider relationships and work to continue this commitment. An important means to support physicians and research will be handled by the newly formed Centene Foundation for Quality Health Care. The Foundation was established to improve the quality, access, effectiveness and value of healthcare for low-income families and individuals. In addition, building on our long-standing commitment to deliver healthcare at the local level, the Foundation will develop partnerships to implement innovative approaches to promote healthy communities.

As always, we remain purposeful, methodical and disciplined. As a leader in the industry, we insist on sound contracting principles, reliable information technology systems, appropriate human resource development and succession planning for the long-term vitality and viability of Centene Corporation. We are committed to building a total *enterprise*, not just building health plans.

In closing, I would like to recognize each of our more than 1,200 dedicated employees for their ongoing commitment, enthusiasm and motivation as we work together to build a first quartile company.

In the coming year, we look forward to the many opportunities to execute on our strategy of being a leader in the Medicaid managed care sector. We will continue our pursuit of excellence, as we reach for the summit, by leading the way in financial transparency, producing solid results and delivering on the promise of better healthcare.

Sincerely,



Michael F. Neidorff
*Chairman and*
*Chief Executive Officer*

# 2004 Operations Review

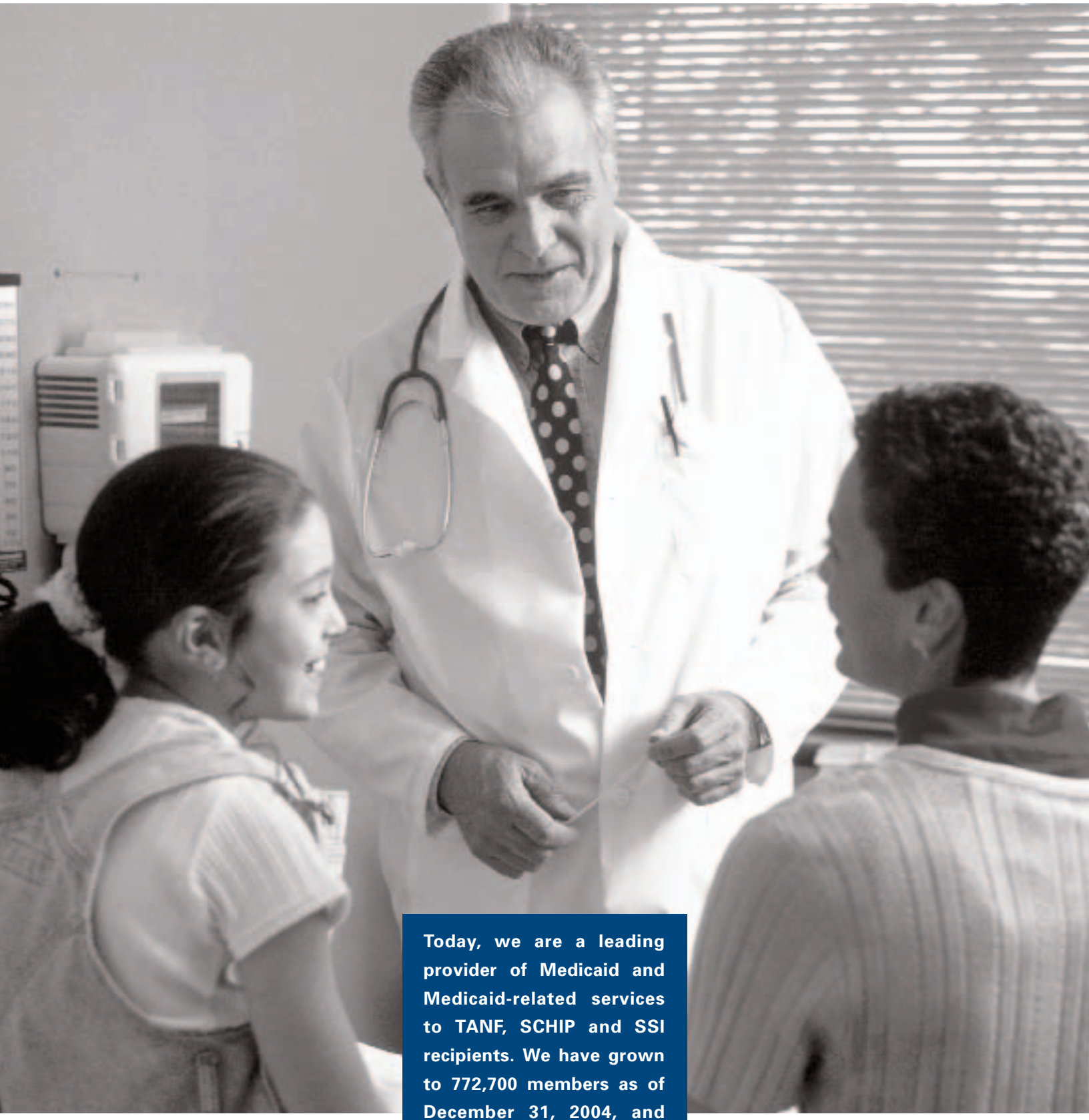
# An Established Company

Founded as a single health plan in Milwaukee in 1984, Centene Corporation has established itself as a leader in the healthcare services field. Today, we are a leading provider of Medicaid and Medicaid-related services to TANF, SCHIP and SSI recipients. We have grown to 772,700 members as of December 31, 2004, and presently operate in seven Medicaid-mandated states.

We are proud of our relationships with these states. In 2004, we won an important Exclusive Provider Organization SCHIP contract that serves recipients in 170 predominantly rural counties in the state of Texas. We are awaiting the results of a Joint Medicaid/CHIP HMO Request For Proposal and look forward to further expansion in the state. The state of Indiana, based on its ongoing commitment to and success with Medicaid managed care, added six new mandated counties in 2004, and we anticipate that the state will add five to seven more in 2005. Recently, there have been new Medicaid managed care entrants in the Indiana market. We are encouraged by the presence of these additional participants as our belief is that growing awareness expands the overall visibility of the Medicaid managed care category and creates an opportunity for increased access to healthcare. In Wisconsin, the state provides ongoing leadership through its BadgerCare program. In New Jersey, we continue to gain valuable experience with the SSI population, and our management team there has demonstrated its confidence and ability to manage the SSI business. We have the systems in place to ensure ongoing success in this category.

Additional growth came with the acquisition of FirstGuard, two health plan entities serving 135,000 members in both Kansas and our home state of Missouri. This transaction will add $250 to $260 million to revenues in the first year. We furthered our expansion in Ohio with the January 2005 announcement of our intent to acquire the Medicaid assets of SummaCare, Inc., a wholly-owned subsidiary of Summa Health System, based in Akron, Ohio. This transaction will add approximately 39,000 members to those already served by our Ohio subsidiary, Buckeye Community Health Plan. When completed, it will accomplish several objectives including building a critical mass of members, increasing our Ohio market share and providing strategic positioning for future expansion in the state.

There are ample opportunities to grow our business both organically and through acquisitions, and we look forward to keeping our stockholders and other key constituencies informed of our progress.



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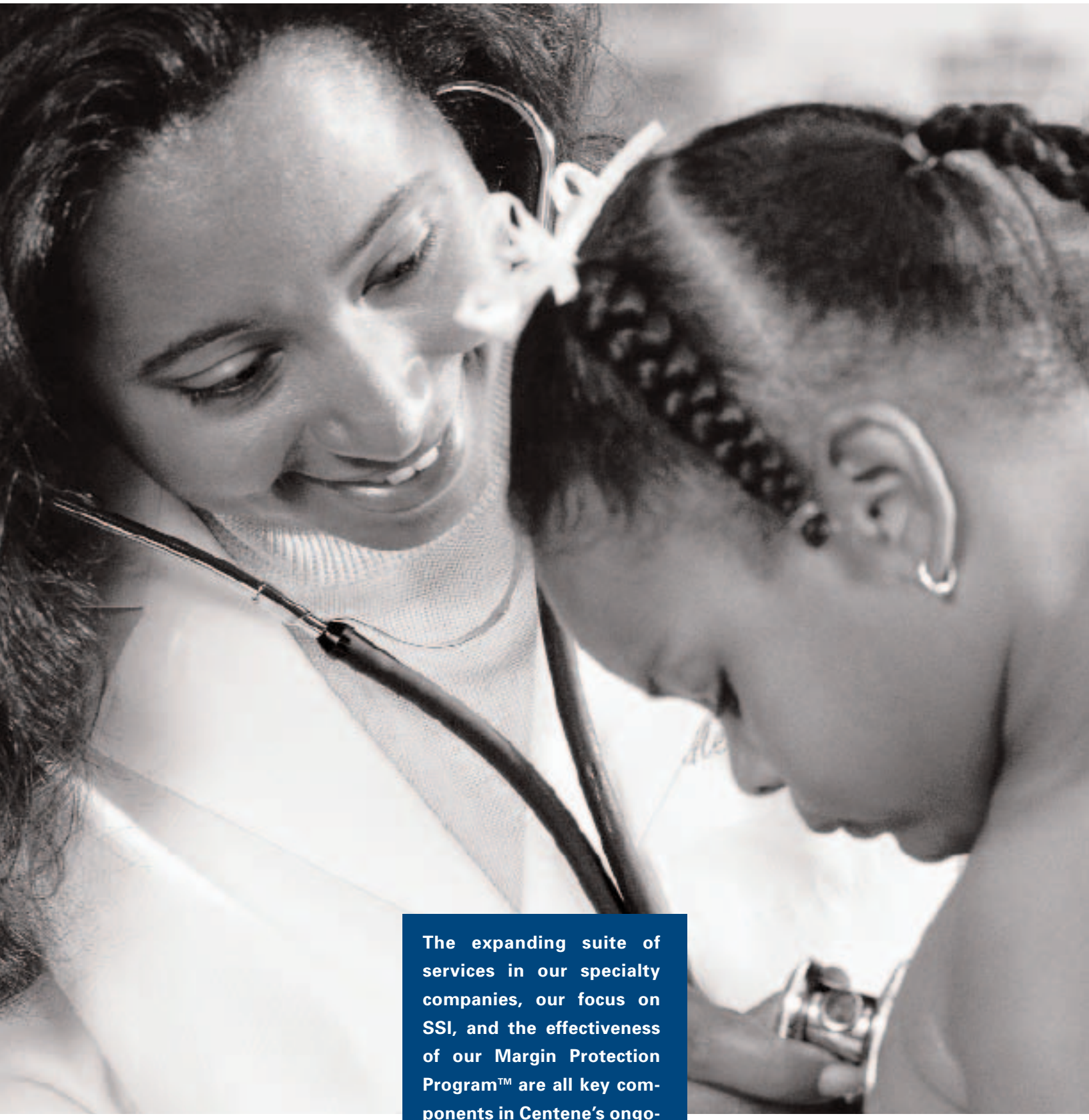


The expanding suite of services in our specialty companies, our focus on SSI, and the effectiveness of our Margin Protection Program™ are all key components in Centene's ongoing success and growth.

# Expanding Our Suite of Services

At Centene, our core philosophy is that quality healthcare is best delivered locally. By recognizing the cultural and ethnic sensitivities of the communities we serve, we are better prepared to act in the best interest of our core constituency – Medicaid recipients. As a result, we have initiated programs designed specifically to meet the needs of our Medicaid population. For example, recipients can access local call centers through our bilingual 24-hour NurseWise® program, which provides access to a broad range of health-related services including health education, urgent pharmacy refills, transportation for treatment and crisis interventions, or enrollment in *STARTSMART* for Your Baby™ for prenatal care. The objectives of these programs remain unchanged, educating members on how to obtain primary care and how to minimize emergency room visits. The result is better health outcomes in a more cost-effective manner.

In addition to our core services, we methodically expanded our suite of specialty services during the year at our CenCorp Health Solutions subsidiary. Within CenCorp is one of our specialty company subsidiaries, Cenpatico Behavioral Health (CBH), formerly known as Group Practice Affiliates. CBH provides managed behavioral healthcare in Indiana, Kansas, Ohio, Texas and Wisconsin. Additionally, CBH applies its behavioral expertise in Arizona by operating programs for emotionally or behaviorally challenged students on regular school campuses. CBH services include, but are not limited to, risk-based utilization management, network development and maintenance, quality improvement, customer service and claims payment for behavioral health practitioners.

Another subsidiary, NurseWise, offers 24/7 nurse advice as well as a treatment adherence program known as *Script*Assist. This program uses registered nurses to counsel and motivate patients about their prescriptions and recommended medical regimen. This capability will be critical as we expand further into the SSI population due to the significant costs stemming from complex physical and behavioral health conditions. We also work with our health plans to support established upper respiratory disease and premature birth prevention programs to provide for more comprehensive care coordination for our Medicaid recipients. We believe that the depth of these programs further enhances positive outcomes for our members and reinforces the predictability of our business model.

The expanding suite of services in our specialty companies, our focus on addressing the SSI population, and the effectiveness of our Margin Protection Program are all key components in Centene's ongoing success and growth in Medicaid managed care.

# A View of Leadership

Centene is a leader in the Medicaid managed care industry at every level. First and foremost, we view ourselves as a responsible participant committed to solving the challenge of escalating healthcare costs and providing more access to care. Our firm belief is that every American is entitled to receive quality healthcare with dignity. For this reason, we established the Centene Foundation for Quality Health Care in July 2004 to provide and support proactive and innovative strategies that improve the quality of and access to healthcare for lower income families.

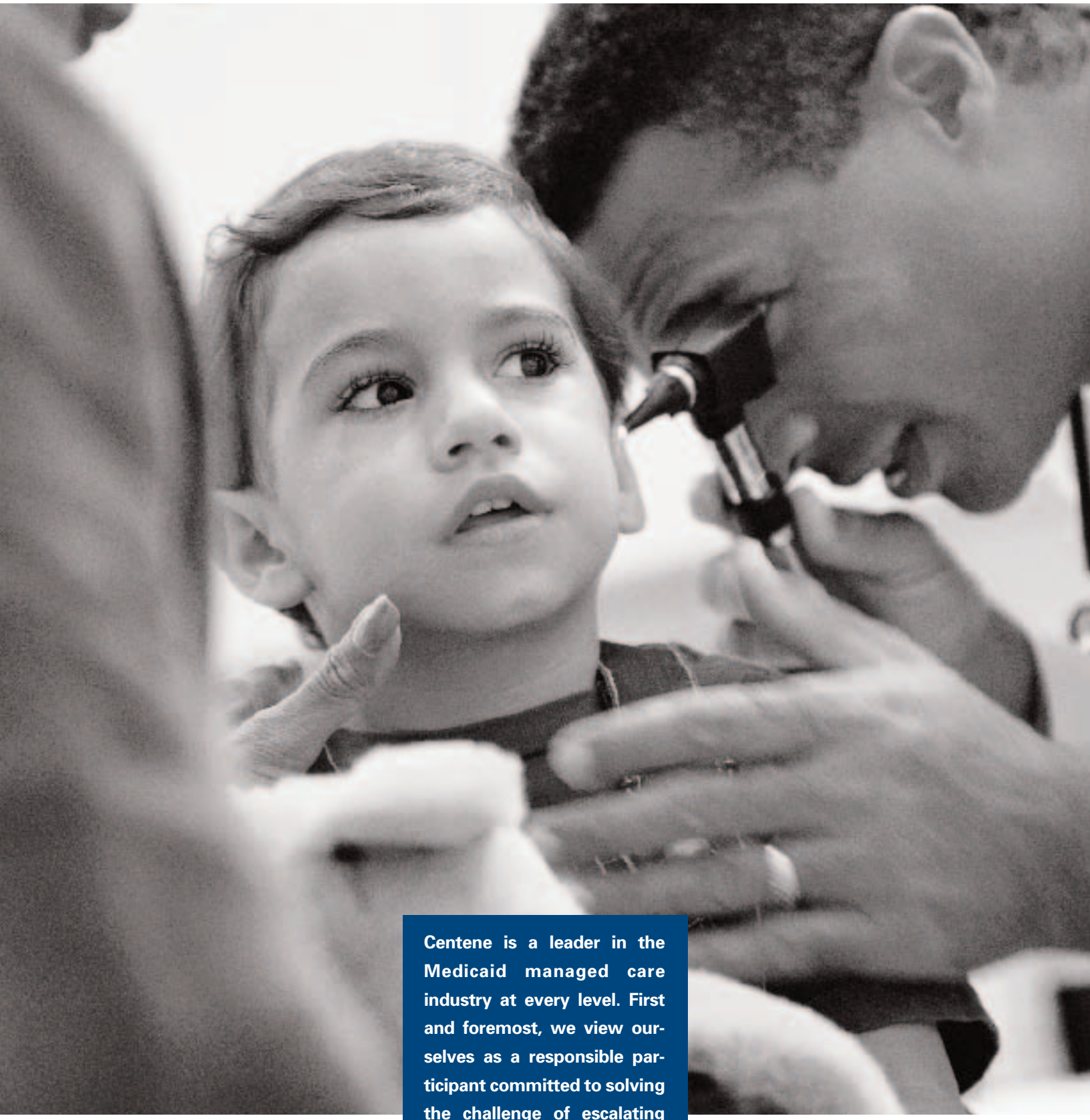
Over three years ago, we developed the concept and the term, Margin Protection Program, to define our approach to working with state governments through a combination of pricing and policy changes to address budget challenges while at the same time enrolling more of the uninsured. For example, our proprietary Emergency Room (ER) program was designed to reduce the number of people who access the ER as their first source of medical care, and our Preferred Drug Lists have helped save money on pharmaceutical costs. We continue to expand our suite of services in order to help states manage better health outcomes and to keep costs down.

We are committed to our principal goal of achieving operational excellence. Our centralized computer and financial systems are maintained at a level which allows us to closely monitor our operations. For example, Centene consistently pays submitted claims well within industry standards, averaging as few as six to seven days from the date of receipt.

Several years ago, we instituted an internal audit process to meet the rigorous requirements of operating as a publicly traded company, which demands accuracy, reliability and accountability of financial reporting. The year 2004 is the first one in which we are required to report in accordance with Section 404 of the Sarbanes-Oxley Act. To that end, we have successfully completed our evaluation and assessment regarding the design and effectiveness of our internal control over financial reporting.

We also strive to give our investors detailed transparency, including segment reporting, to help them understand our business. We are one of only a few public companies in the healthcare services sector that files its Quarterly Report on Form 10-Q concurrent with its earnings release, a testimony to the strength of the systems that we have in place.

We are disciplined purchasers and our acquisition criteria remain unchanged. Transactions must have an acceptable rate of return, be accretive within the first 12 months and give us organic growth opportunities in Medicaid-mandated states. In 2004, we completed two of 44 transactions after intensive due diligence and evaluation as we fundamentally believe that acquisitions can materially change the risk profile of our Company. By being methodical and unyielding in our approach, we feel that we can minimize this risk while increasing the opportunity for sustained stockholder value.



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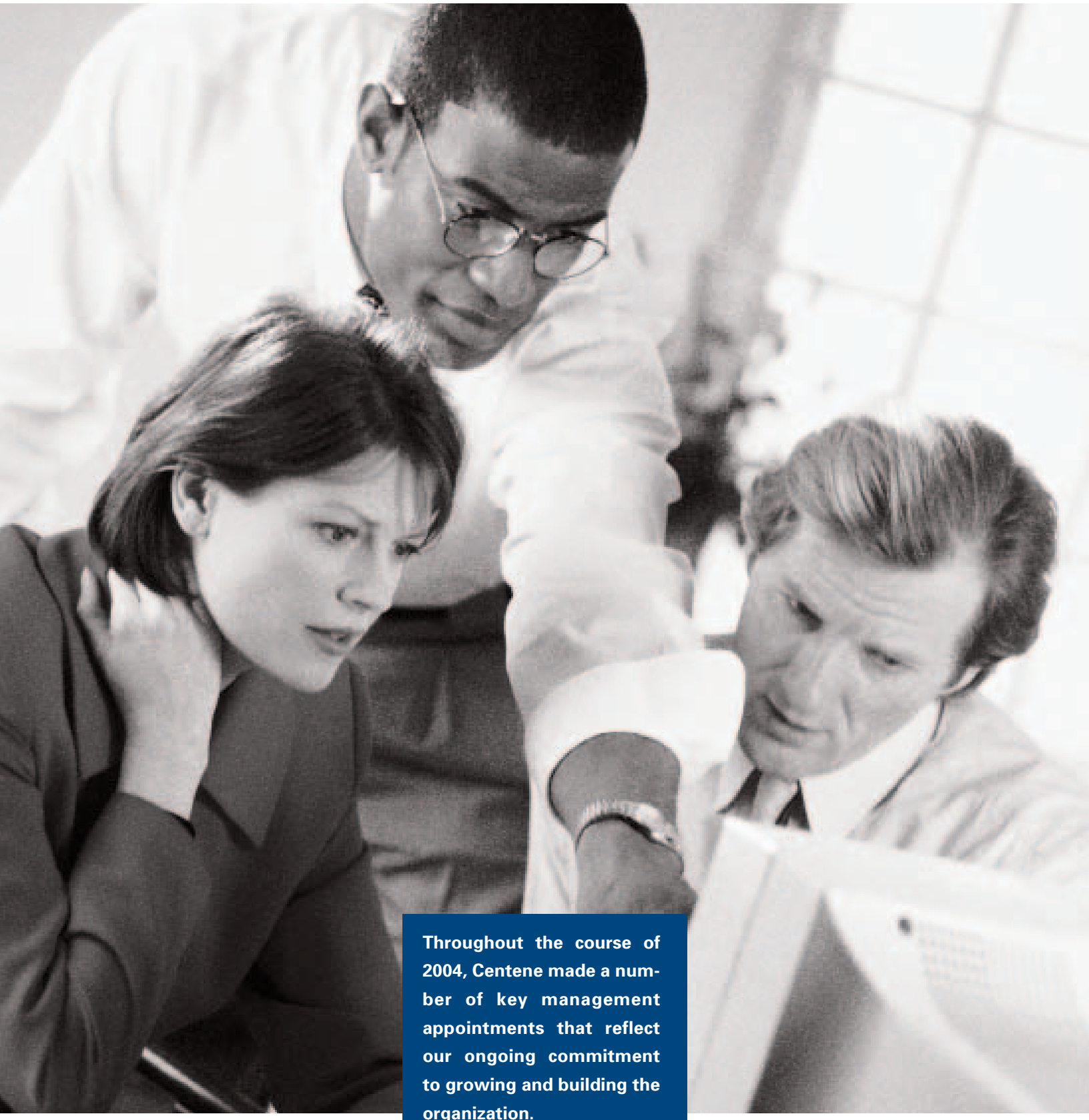


**Throughout the course of 2004, Centene made a number of key management appointments that reflect our ongoing commitment to growing and building the organization.**

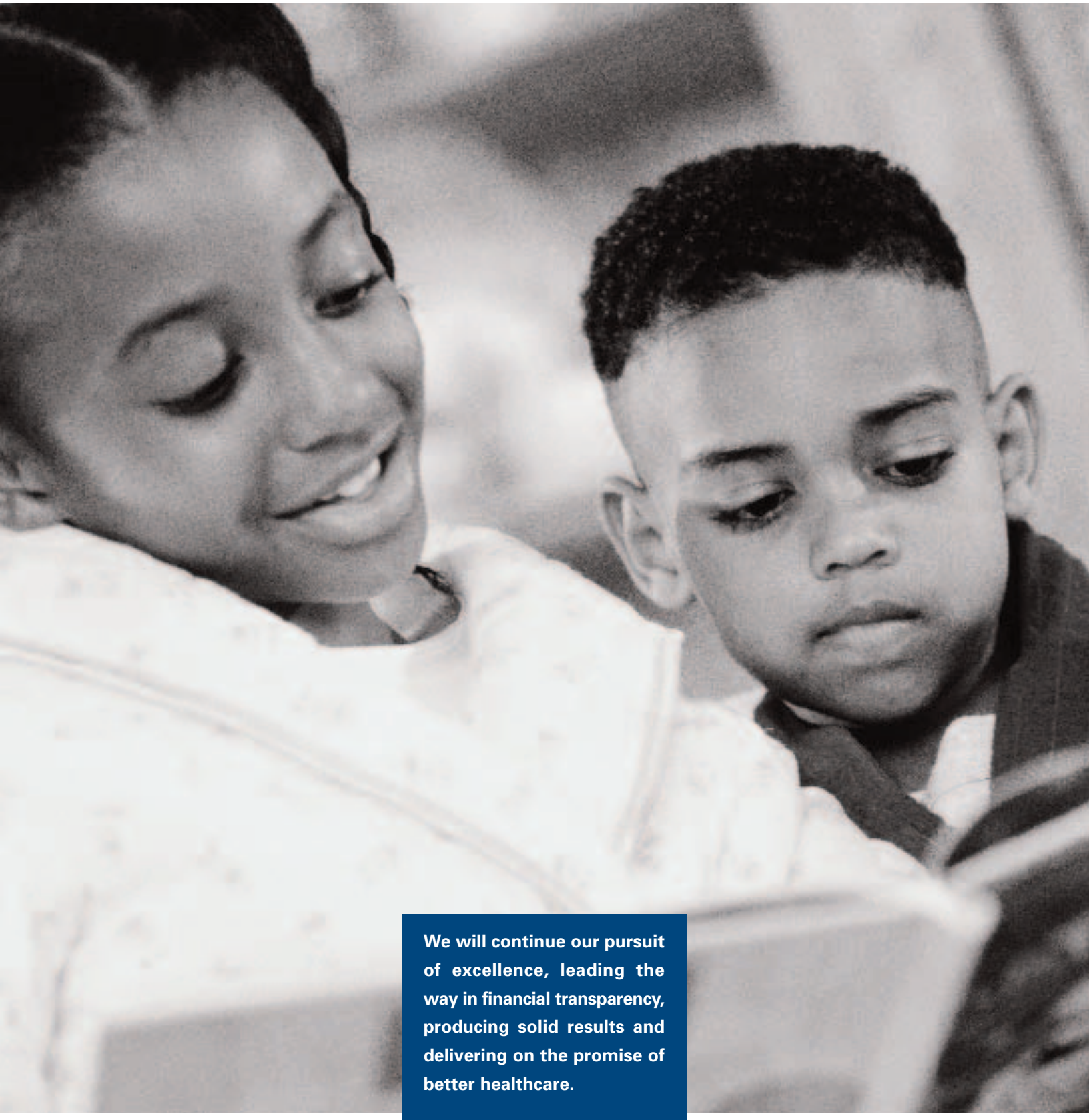
# Enhancing Our Team

Throughout the course of 2004, Centene made a number of key management appointments that reflect our ongoing commitment to growing and building the organization. We continue to embrace the philosophy of entering new businesses only when the appropriate talent is in place to manage them. During the year, we initiated a full blown succession planning program that will ensure that the organization develops at the same or greater rate than the business. This further supports continuity in times of unforeseen disruptions and it is all part of our goal of purposefully building and sustaining a *multi-line* enterprise.

This year's appointments exemplify the addition of skill sets and talent that are integral to implementing our strategic plan and building a purposeful *multi-line* Medicaid managed care company. Centene's board of directors was strengthened with the addition of Steve Bartlett, President and Chief Executive Officer of The Financial Services Roundtable, and John R. Roberts, Executive Director, Civic Progress of St. Louis.

There were also strategic management appointments and additions made within Centene's operations. Notably, James D. Donovan, Jr. joined as Senior Vice President, New Products and New Markets, and is responsible for the development and implementation of new products and leading our expansion into new states. Mr. Donovan has more than 30 years of experience in the managed care industry. Lisa M. Wilson, Senior Vice President, Investor Relations, joined Centene in March after successfully representing the Company since its initial public offering in 2001. She brings over 15 years of experience in investor relations and equity capital markets. Samuel A. Donaldson, Ph.D., was named President and Chief Executive Officer of Cenpatico Behavioral Health. Dr. Donaldson's extensive career in behavioral health services and strong record of accomplishment in the execution and implementation of specialty company strategies will be important as we grow this segment of our business. Patricia J. Darnley was appointed as President and Chief Executive Officer of University Health Plans, our New Jersey health plan based in Newark. With over 20 years of industry-related experience, she will oversee our ongoing expansion there. Finally, Kimberly D. Tuck was appointed President and Chief Executive Officer of NurseWise, a subsidiary of Centene's specialty company, CenCorp Health Solutions. With more than 24 years of healthcare experience, she will further develop the NurseWise product and assist with future expansion.

As always, we work diligently to attract, cultivate and retain employees at all levels, while remaining focused on maintaining our general and administrative expenses at acceptable levels.



**We will continue our pursuit of excellence, leading the way in financial transparency, producing solid results and delivering on the promise of better healthcare.**

# Financial Review

# Quarterly Selected Financial Information *(Unaudited)*

| *(In thousands, except share data and membership data)* | *For the Quarter Ended,* March 31, **2004** | June 30, **2004** | September 30, **2004** | December 31, **2004** |
|---|---|---|---|---|
| Total revenues | **$225,525** | **$233,608** | **$253,743** | **$288,064** |
| Earnings from operations | **14,684** | **15,937** | **16,471** | **17,444** |
| Earnings before income taxes | **16,104** | **17,172** | **18,028** | **18,983** |
| Net earnings | **$ 10,138** | **$ 10,813** | **$ 11,351** | **$ 12,010** |
| Per share data: | | | | |
| Basic earnings per common share | **$ 0.25** | **$ 0.27** | **$ 0.28** | **$ 0.29** |
| Diluted earnings per common share | **$ 0.24** | **$ 0.25** | **$ 0.26** | **$ 0.27** |
| Period end membership | **522,400** | **533,300** | **641,600** | **772,700** |

| | *For the Quarter Ended,* March 31, 2003 | June 30, 2003 | September 30, 2003 | December 31, 2003 |
|---|---|---|---|---|
| Total revenues | $177,434 | $186,232 | $198,753 | $207,311 |
| Earnings from operations | 10,147 | 10,336 | 12,640 | 13,804 |
| Earnings before income taxes | 11,094 | 11,589 | 13,814 | 15,396 |
| Net earnings | $ 7,161 | $ 7,708 | $ 8,704 | $ 9,697 |
| Per share data: | | | | |
| Basic earnings per common share | $ 0.22 | $ 0.23 | $ 0.24 | $ 0.24 |
| Diluted earnings per common share | $ 0.20 | $ 0.22 | $ 0.22 | $ 0.23 |
| Period end membership | 419,300 | 438,700 | 467,100 | 489,600 |

# Selected Financial Data

| *(In thousands, except share data)* | *Year Ended December 31,* 2004 | 2003 | 2002 | 2001 | 2000 |
|---|---|---|---|---|---|
| **Statement of Earnings Data:** | | | | | |
| Revenues: | | | | | |
| Premiums | $ 991,673 | $759,763 | $461,030 | $326,184 | $216,414 |
| Services | 9,267 | 9,967 | 457 | 385 | 4,936 |
| Total revenues | 1,000,940 | 769,730 | 461,487 | 326,569 | 221,350 |
| Expenses: | | | | | |
| Medical costs | 800,476 | 626,192 | 379,468 | 270,151 | 182,495 |
| Cost of services | 8,065 | 8,323 | 341 | 329 | 135 |
| General and administrative expenses | 127,863 | 88,288 | 50,072 | 37,617 | 32,200 |
| Total operating expenses | 936,404 | 722,803 | 429,881 | 308,097 | 214,830 |
| Earnings from operations | 64,536 | 46,927 | 31,606 | 18,472 | 6,520 |
| Other income (expense): | | | | | |
| Investment and other income | 6,431 | 5,160 | 9,575 | 3,916 | 1,784 |
| Interest expense | (680) | (194) | (45) | (362) | (611) |
| Equity in losses from joint ventures | – | – | – | – | (508) |
| Earnings before income taxes | 70,287 | 51,893 | 41,136 | 22,026 | 7,185 |
| Income tax expense (benefit) | 25,975 | 19,504 | 15,631 | 9,131 | (543) |
| Minority interest | – | 881 | 116 | – | – |
| Net earnings | 44,312 | 33,270 | 25,621 | 12,895 | 7,728 |
| Accretion of redeemable preferred stock | – | – | – | (467) | (492) |
| Net earnings attributable to common stockholders | $ 44,312 | $ 33,270 | $ 25,621 | $ 12,428 | $ 7,236 |
| Net earnings per common share: | | | | | |
| Basic | $ 1.09 | $ 0.93 | $ 0.82 | $ 2.99 | $ 2.68 |
| Diluted | $ 1.02 | $ 0.87 | $ 0.73 | $ 0.54 | $ 0.38 |
| Weighted average common shares outstanding: | | | | | |
| Basic | 40,820,909 | 35,704,426 | 31,432,080 | 4,156,198 | 2,704,578 |
| Diluted | 43,616,445 | 38,422,152 | 34,932,232 | 24,058,492 | 20,458,786 |

| *(In thousands)* | *December 31,* 2004 | 2003 | 2002 | 2001 | 2000 |
|---|---|---|---|---|---|
| **Balance Sheet Data:** | | | | | |
| Cash and cash equivalents | $ 84,105 | $ 64,346 | $ 59,656 | $ 88,867 | $ 19,023 |
| Investments | 211,070 | 199,971 | 89,237 | 22,288 | 21,859 |
| Total assets | 527,934 | 362,692 | 210,327 | 131,366 | 66,017 |
| Medical claims liabilities | 165,980 | 106,569 | 91,181 | 59,565 | 45,805 |
| Debt | 47,459 | 8,195 | – | – | 4,000 |
| Redeemable convertible preferred stock | – | – | – | – | 18,878 |
| Total stockholders' equity (deficit) | 271,312 | 220,115 | 102,183 | 64,089 | (8,834) |

# Management's Discussion and Analysis of Financial Condition and Results of Operations

*The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this annual report. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under "Factors That May Affect Future Results and The Trading Price of Our Common Stock."*

## Overview

We are a multi-line managed care organization that provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). We have health plans in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin. We also provide specialty services in each of the states where we have health plans as well as free-standing programs in Arizona, California and Colorado. These specialty services include behavioral health, nurse triage and treatment compliance.

We have organized this Management's Discussion and Analysis to address the following:

- Recent Acquisitions;
- Critical Accounting Policies;
- Revenue and Expense Discussion and Key Metrics;
- Results of Operations;
- Liquidity and Capital Resources;
- Regulatory Capital and Dividend Restrictions.

## Recent Acquisitions

Effective December 1, 2004, we acquired FirstGuard, Inc. and FirstGuard Health Plan, Inc., or FirstGuard, for a purchase price of approximately $96.1 million. FirstGuard serves approximately 135,000 members in Kansas and Missouri. The results of operations of this entity are included in our consolidated financial statements beginning December 1, 2004. The preliminary purchase price allocation resulted in estimated identifiable intangible assets of $8.0 million and goodwill of $86.8 million. The estimated identifiable intangible assets are being amortized over an estimated life of 10 years.

Effective January 1, 2004, we commenced operations in Ohio through the acquisition of the Medicaid-related assets of Family Health Plan, Inc. for a purchase price of $6.9 million. We are currently serving 23,800 members in Toledo, Ohio. The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2004. The purchase price allocation resulted in identified intangible assets of $1.8 million, representing purchased contract rights, provider network and a non-compete agreement, and goodwill of $5.1 million. The contract rights, provider network and non-compete agreement are being amortized over periods ranging from five to 10 years.

Effective August 1, 2003, we acquired the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market. This transaction allows us to serve approximately 17,000 additional members in the state. The purchase price of $1.0 million was allocated to acquired contracts. The contracts are being amortized over a period of five years, the expected period of benefit.

During 2003, we acquired a 100% ownership interest in Group Practice Affiliates, LLC, a behavioral healthcare services company (63.7% in March 2003 and 36.3% in August 2003). In September 2004, we renamed this subsidiary Cenpatico Behavioral Health, LLC, or Cenpatico. This acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. We paid an aggregate purchase price of $1.8 million for Cenpatico, assumed net liabilities of $1.9 million and recorded goodwill of $3.7 million related to the acquisition.

In March 2003, we purchased certain assets of *Script*Assist, a treatment compliance company. We are administering the purchased contracts under the *Script*Assist name. *Script*Assist uses various approaches and medical expertise to promote adherence to prescription drugs. The asset acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. The purchase price of $563,000 was allocated to acquired contracts. We are amortizing the contracts over five years, the expected period of benefit.

On December 1, 2002, we acquired 80% of the outstanding capital stock of University Health Plans, Inc., or UHP, from University of Medicine and Dentistry of New Jersey. In October 2003 we exercised our option to purchase the remaining 20%. UHP is a managed health plan operating in 20 counties in New Jersey. We paid an aggregate purchase price of $13.3 million for our interest in UHP. The purchase price allocation resulted in intangible assets of $3.8 million representing provider contracts and purchased contract rights, which are being amortized over 10 years, and goodwill of $5.0 million.

In June 2002, we entered into an agreement with Texas Universities Health Plan Inc. to purchase the SCHIP contracts in three Texas service areas, thereby adding approxi-

mately 24,000 members to our Texas health plan. The cash purchase price of $595,000 was recorded as purchased contract rights, which are being amortized over five years, the expected period of benefit.

With our acquisition of Cenpatico and our purchase of *Script*Assist assets, we began operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of our regulated subsidiaries, including all of the functions needed to operate them. The Specialty Services segment consists of our specialty services, including our behavioral health, nurse triage and treatment compliance functions.

## Critical Accounting Policies

Our significant accounting policies are more fully described in Note 3 to our annual consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liabilities and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty.

### Medical Claims Liabilities

Our medical claims liabilities include claims reported but not yet paid, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims. We, together with our independent actuaries, estimate medical claims liabilities using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors. These estimates are continually reviewed each period and adjustments based on actual claim submissions and additional facts and circumstances are reflected in the period known.

Our management uses its judgment to determine the assumptions to be used in the calculation of the required estimates. In developing our estimate for IBNR, we apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital claims are estimated based on authorized days and historical per diem claim experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. These approaches are consistently applied to each period presented.

The completion factor, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2004 data:

| Completion Factors[a] | | Cost Trend Factors[b] | |
|---|---|---|---|
| (Decrease) Increase in Factors | Increase (Decrease) in Medical Claims Liabilities *(in thousands)* | (Decrease) Increase in Factors | Increase (Decrease) in Medical Claims Liabilities *(in thousands)* |
| (3)% | $ 17,000 | (3)% | $(4,700) |
| (2)% | 11,200 | (2)% | (3,100) |
| (1)% | 5,600 | (1)% | (1,600) |
| 1% | (5,400) | 1% | 1,600 |
| 2% | (10,800) | 2% | 3,200 |
| 3% | (16,000) | 3% | 4,800 |

[a] *Reflects estimated potential changes in medical claims liabilities caused by changes in completion factors.*

[b] *Reflects estimated potential changes in medical claims liabilities caused by changes in cost trend factors for the most recent periods.*

While we believe these estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liabilities would have affected net earnings by $1.0 million for the year ended December 31, 2004. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our customers and information available from other outside sources, as appropriate.

The change in medical claims liabilities is summarized as follows (in thousands):

| | *Year Ended December 31,* | | |
|---|---|---|---|
| | **2004** | **2003** | **2002** |
| Balance, January 1 | **$106,569** | $ 91,181 | $ 59,565 |
| Acquisitions | **24,909** | 335 | 16,230 |
| Incurred related to: | | | |
| Current year | **816,418** | 645,482 | 396,715 |
| Prior years | **(15,942)** | (19,290) | (17,247) |
| Total incurred | **800,476** | 626,192 | 379,468 |
| Paid related to: | | | |
| Current year | **681,780** | 544,309 | 324,210 |
| Prior years | **84,194** | 66,830 | 39,872 |
| Total paid | **765,974** | 611,139 | 364,082 |
| Balance, December 31 | **$165,980** | $106,569 | $ 91,181 |
| Claims inventory, December 31 | **150,000** | 131,000 | 151,000 |
| Days in claims liability[a] | **66.5** | 59.0 | 71.8 |

[a] *Days in claims liability is a calculation of medical claims liabilities at the end of the period divided by average expense per calendar day for the fourth quarter of each year. Acquisitions in the last quarter of 2004 and 2002 contributed to an increase in our days in claims liability calculation.*

Acquisitions in 2004 include reserves acquired in connection with our acquisition of FirstGuard. Acquisitions in 2003 and 2002 include reserves acquired in connection with our acquisition of UHP.

Medical claims are usually paid within a few months of the member receiving service from the physician or other health-care provider. As a result, these liabilities generally are described as having a "short-tail," which causes less than 10% of our medical claims liabilities as of the end of any given year to be outstanding the following year. Management expects that substantially all the development of the estimate of medical claims liabilities as of December 31, 2004, will be known by the end of 2005.

Actuarial Standards of Practice generally require that medical claims liabilities estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be less than the estimate that satisfies the Actuarial Standards of Practice.

Changes in estimates of incurred claims for prior years were attributable to favorable development in all of our markets, including changes in medical utilization and cost trends. These changes in medical utilization and cost trends can be attributable to our "margin protection" programs and changes in our member demographics. For example, our membership increased 38.3% during the fourth quarter of 2002. This member growth led to changes in our medical utilization and cost trends that were subject to estimates at December 31, 2002. For all of our membership, we routinely implement new or modified policies that we refer to as our "margin protection" programs that assist with the control of medical utilization and cost trends such as emergency room policies. While we try to predict the savings from these programs, actual savings have proven to be better than anticipated, which has contributed to the favorable development of our medical claims liabilities.

### Intangible Assets

We have made several acquisitions since 2002 that have resulted in our recording of intangible assets. These intangible assets primarily consist of non-compete agreements, purchased contract rights, provider contracts and goodwill. At December 31, 2004, we have outstanding $101.6 million of goodwill and $14.4 million of net other intangible assets. Non-compete agreements are amortized using the straight-line method over 60 months. Purchased contract rights are amortized using the straight-line method over periods ranging from 60 to 120 months. Provider contracts are amortized using the straight-line method over 120 months.

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows generated from the use and ultimate disposition of the respective acquired entity. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed at each year-end for impairment. In addition, we will perform an impairment analysis of other intangible assets based on other factors. These factors would include significant changes in membership, state funding, medical contracts and provider networks and contracts. We did not recognize any impairment losses during the three years ended December 31, 2004.

## Revenue and Expense Discussion and Key Metrics

### Revenues and Revenue Recognition

We generate revenues in our Medicaid Managed Care segment primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. These adjustments are immaterial in relation to total revenue recorded and are reflected in the period known, typically within two months.

Our Specialty Services companies generate revenues from a variety of sources. Our behavioral health company generates revenue via capitation payments from our health plans and others. It also receives fees for the direct provision of care and certain school programs in Arizona. Our treatment compliance program receives fee income from the manufacturers of pharmaceuticals. Our nurse triage line receives fees from health plans, physicians and other organizations for providing continuous access to nurse advisors.

Premiums collected in advance are recorded as unearned revenue. Premiums due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectibility of these accounts. As we generally receive premiums during the month in which services are provided, the allowance is typically not significant in comparison to total premium revenue and does not have a material impact on the presentation of our financial condition or results of operations.

The primary drivers of our increasing revenue have been membership growth in our Medicaid Managed Care segment. We have increased our membership through internal growth and acquisitions. From December 31, 2002 to December 31, 2004, we increased our membership by 88.6%. The following table sets forth our membership by state:

| | *December 31,* | | |
|---|---|---|---|
| | **2004** | **2003** | **2002** |
| Indiana | **150,600** | 119,400 | 105,700 |
| Kansas | **94,200** | – | – |
| Missouri | **41,200** | – | – |
| New Jersey | **52,800** | 54,000 | 52,900 |
| Ohio | **23,800** | – | – |
| Texas | **244,300** | 158,400 | 118,000 |
| Wisconsin | **165,800** | 157,800 | 133,000 |
| Total | **772,700** | 489,600 | 409,600 |

The following table sets forth our membership by line of business:

| | *December 31,* | | |
|---|---|---|---|
| | **2004** | **2003** | **2002** |
| Medicaid | **580,200** | 411,800 | 336,100 |
| SCHIP | **182,100** | 68,400 | 65,900 |
| SSI | **10,400** | 9,400 | 7,600 |
| Total | **772,700** | 489,600 | 409,600 |

In 2004, we entered the Kansas and Missouri markets through our acquisition of FirstGuard and the Ohio market with our acquisition of the Medicaid-related assets of Family Health Plan, Inc. We increased our Texas membership by approximately 87,500 members from the EPO contract award effective September 1, 2004. Our membership increased in Indiana and Wisconsin from additions to our provider network, increases in counties served and growth in the overall number of Medicaid beneficiaries.

In 2003, our membership increased by 17,000 members in Texas due to the purchase of contract rights from HMO Blue Texas. Our membership increased in all our markets from additions to our provider network, increases in counties served and growth in the overall number of Medicaid beneficiaries.

In 2002, our membership increased by 24,000 members in Texas due to the purchase of SCHIP contract rights from Texas Universities Health Plan. In addition, two smaller plans exited the Austin, Texas market. As a result, our Texas plan increased its membership by 28,000 members. This increase includes approximately 12,000 members that we managed for the state of Texas on an interim basis. We entered the New Jersey market through our acquisition of UHP. Membership increases in our Wisconsin and Indiana markets resulted from additions to our provider network and growth in the overall number of Medicaid beneficiaries.

### Operating Expenses

Our operating expenses include medical costs, cost of services, and general and administrative expenses.

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty product claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. As part of this review, we also consider the costs to process medical claims and estimates of amounts to cover uncertainties related to fluctuations in physician billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize the services of independent actuaries who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claim costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our health benefits ratio represents medical costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our health benefits ratios by member category and in total:

| | *Year Ended December 31,* | | |
|---|---|---|---|
| | **2004** | **2003** | **2002** |
| Medicaid and SCHIP | **80.4%** | 81.7% | 82.2% |
| SSI | **93.8** | 102.5 | 100.7 |
| Total | **80.7** | 82.4 | 82.3 |

Our Medicaid and SCHIP ratio decreased in 2004 from 2003 due primarily to initiatives to reduce inappropriate emergency room usage and to establish preferred drug lists such as generics. The addition of the SSI members resulting from our acquisition in New Jersey in December 2002 caused our total health benefits ratio to increase slightly in 2003. The health benefits ratio for SSI is affected by a low membership base and is subject to greater volatility as a percentage of premiums (although relatively immaterial in total dollars to total medical costs).

Our cost of services expenses include all direct costs to support the local functions responsible for generation of our services revenues. These expenses primarily consist of the salaries and wages of the physicians, clinicians, therapists and teachers who provide the services and expenses related to facilities and equipment used to provide services.

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to health plans, specialty companies and our centralized functions that support all of our business units. The major centralized functions are claims processing, information systems and finance. Premium taxes are classified as general and administrative expenses. Our general and administrative expense ratio represents general and administrative expenses as a percentage of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues. The following table sets forth the general and administrative expense ratios by business segment and in total:

| | *Year Ended December 31,* | | |
|---|---|---|---|
| | **2004** | **2003** | **2002** |
| Medicaid Managed Care | **10.7%** | 10.3% | 10.9% |
| Specialty Services | **52.3** | 38.2 | – |
| Total | **12.8** | 11.5 | 10.9 |

The increase in the Medicaid Managed Care general and administrative expenses ratio in 2004 reflects the impact of premium taxes enacted in September 2003 in Texas and July 2004 in New Jersey. These taxes totaled $5.5 million in 2004 and $1.4 in 2003 and had the effect of increasing our general and administrative expenses ratio by 0.5% in 2004 and 0.2% in 2003. Additionally, the 2004 results include 1) start-up costs associated with the Texas EPO contract, our claims processing facility in Montana and FirstGuard, 2) severance costs related to job eliminations, and 3) higher compensation costs related to our performance bonus plans.

The Specialty Services ratio may vary depending on the various contracts and nature of the services provided and will have a higher general and administrative expense ratio than the Medicaid Managed Care segment. The 2004 results were affected by expenses associated with transitioning certain activities within Specialty Services, including closing costs of our clinic facilities in Texas and California as Cenpatico fully transitions to a third-party service model for behavioral health services, due diligence costs related to a potential transaction we decided not to pursue and costs related to investing in new business opportunities.

### Other Income (Expense)

Other income (expense) consists principally of investment and other income and interest expense.

- Investment income is derived from our cash, cash equivalents and investments. Information about our investments is included below under "Liquidity and Capital Resources."
- Interest expense reflects interest on the borrowings under our credit facility, fees in conjunction with our credit facility and mortgage interest.

## Results of Operations

### Year Ended December 31, 2004 Compared to Year Ended December 31, 2003

Summarized comparative financial data for 2004 and 2003 are as follows ($ in millions):

| | | | *% Change* |
|---|---|---|---|
| | **2004** | **2003** | **2003–2004** |
| Premium revenue | **$ 991.7** | $759.7 | 30.5% |
| Services revenue | **9.2** | 10.0 | (7.0)% |
| Total revenues | **1,000.9** | 769.7 | 30.0% |
| Medical costs | **800.5** | 626.2 | 27.8% |
| Cost of services | **8.1** | 8.3 | (3.1)% |
| General and administrative expenses | **127.8** | 88.3 | 44.8% |
| Earnings from operations | **64.5** | 46.9 | 37.5% |
| Investment and other income, net | **5.8** | 5.0 | 15.8% |
| Earnings before income taxes | **70.3** | 51.9 | 35.4% |
| Income tax expense | **26.0** | 19.5 | 33.2% |
| Minority interest | **–** | .9 | – |
| Net earnings | **$ 44.3** | $ 33.3 | 33.2% |
| Diluted earnings per common share | **$ 1.02** | $ 0.87 | 17.2% |

### Revenues

Total revenues for the year ended December 31, 2004 increased 30.0% from the comparable period in 2003. This increase was due to organic growth in our existing markets; the addition of EPO members in Texas, effective September 1, 2004; the acquisition of the Medicaid related assets of Family Health Plan, effective January 1, 2004; and the acquisition of FirstGuard, effective December 1, 2004. Additionally, we received premium rate increases ranging from 2.3% to 5.3%, or 4.4% on a composite basis across our markets.

### Operating Expenses

Medical costs increased 27.8% due to the growth in our membership as discussed above. Our health benefits ratio decreased to 80.7% from 82.4% primarily due to continued

improvements in our initiatives to reduce emergency room usage and to establish preferred drug lists throughout all our markets.

General and administrative expenses increased 44.8% primarily due to expenses for additional staff to support our membership growth, expansion into the Specialty Services segment, the effect of a premium tax in two states and start-up costs related to our acquisition of FirstGuard, the EPO contract and our claims processing facility in Montana.

### Other Income

Investment and other income increased 15.8% as a result of higher average investment balances and an increase in market interest rates partially offset by higher interest expense from increased borrowings under our credit facility and mortgages.

### Income Tax Expense

Our effective tax rate in 2004 was 37.0%, compared to 37.6% in 2003. The decrease was primarily due to a lower effective state tax rate.

### Earnings Per Share and Shares Outstanding

Our earnings per share calculations reflect an increase in the weighted average shares outstanding in 2004 primarily resulting from the follow-on offering of 6,900,000 common shares sold in August 2003.

## Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

Summarized comparative financial data for 2003 and 2002 are as follows ($ in millions):

| | 2003 | 2002 | % Change 2002–2003 |
|---|---|---|---|
| Premium revenue | $759.7 | $461.0 | 64.8% |
| Services revenue | 10.0 | .5 | – |
| Total revenues | 769.7 | 461.5 | 66.8% |
| Medical costs | 626.2 | 379.5 | 65.0% |
| Cost of services | 8.3 | .3 | – |
| General and administrative expenses | 88.3 | 50.1 | 76.3% |
| Earnings from operations | 46.9 | 31.6 | 48.5% |
| Investment and other income, net | 5.0 | 9.5 | (47.9)% |
| Earnings before income taxes | 51.9 | 41.1 | 26.1% |
| Income tax expense | 19.5 | 15.6 | 24.8% |
| Minority interest | .9 | .1 | – |
| Net earnings | $ 33.3 | $ 25.6 | 29.9% |
| Diluted earnings per common share | $ 0.87 | $ 0.73 | 19.2% |

### Revenues

Premiums for the year ended December 31, 2003, increased 64.8% from the comparable period in 2002. This increase was due to organic growth in our existing markets, changes in our member mix by product category, the purchase of the Texas contracts and the addition of our New Jersey membership through our acquisition of UHP, effective December 1, 2002. In addition, we received premium rate increases ranging from 1.0% to 7.5%, or 4.6% on a composite basis across our markets.

Services revenues increased due to an increase in our non-risk SSI membership in our Texas market and the addition of services revenues of Cenpatico beginning March 1, 2003.

### Operating Expenses

Medical costs increased 65.0% due to the growth in our membership as discussed above. Our Medicaid and SCHIP health benefits ratio decreased to 81.7% from 82.2% due in part to our initiatives to reduce emergency room usage and to establish preferred drug lists.

Cost of services increased due to the inclusion of direct costs related to the services revenues of Cenpatico beginning March 1, 2003.

General and administrative expenses increased 76.3% primarily due to expenses for additional staff to support our membership growth and expansion into the Specialty Services segment. Additionally, general and administrative expenses increased as a result of the institution of a premium tax, tax planning costs incurred during the year and Ohio start-up costs.

### Other Income

Other income (expense) in 2002 included a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment. Excluding this one-time gain, other income increased from 2002 with higher investment balances in 2003 partially offset by a lower interest rate environment and interest expense on our corporate headquarters' mortgage.

### Income Tax Expense

Our effective tax rate in 2003 was 37.6%, compared to 38.0% in 2002. The decrease was primarily due to increased levels of tax-exempt interest income and a lower effective state tax rate.

### Earnings Per Share and Shares Outstanding

Our earnings per share calculations reflect an increase in the weighted average shares outstanding in 2003 primarily resulting from the follow-on offering of 6,900,000 common shares sold in August 2003.

## Liquidity and Capital Resources

Our operating activities provided cash of $99.4 million in 2004, $56.0 million in 2003 and $39.7 million in 2002. The increases were due primarily to continued profitability, increases in membership and increases in medical claims liabilities.

Our investing activities used cash of $122.5 million in 2004, $140.7 million in 2003 and $79.7 million in 2002. During 2004, our investing activities primarily consisted of the acquisition of FirstGuard. In 2003 and 2002, the largest component of investing activities related to increases in our investment portfolio as a result of our stock offerings in those years. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2004, our investment portfolio consisted primarily of fixed-income securities with an average duration of 1.8 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, insurance contracts, commercial paper and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

Our financing activities provided cash of $42.8 million in 2004, $89.4 million in 2003 and $10.8 million in 2002. During 2004, our financing activities primarily consisted of borrowings under our credit facility. These borrowings were used primarily for our investing activities in conjunction with the acquisition of FirstGuard. During 2003, our financing cash flows primarily consisted of the proceeds from the issuance of common stock through our public offering completed in August 2003. During 2002, financing cash flows primarily consisted of the issuance of common stock through our offering completed in June 2002.

We spent $14.7 million and $6.6 million in 2004 and 2003, respectively, on capital assets consisting primarily of new software, software and hardware upgrades, and furniture, equipment and leasehold improvements related to office and market expansions. In 2002, we purchased $3.9 million of furniture, equipment and leasehold improvements. We anticipate spending $16.8 million on additional capital expenditures in 2005 related to office and market expansions and system upgrades.

During 2004, we purchased the property adjacent to our corporate headquarters in St. Louis, Missouri for an aggregate purchase price of $10.3 million. This property will be used for the future expansion of our corporate offices. We financed a portion of the purchase price through a $5.5 million non-recourse mortgage loan arrangement. In July 2003, we purchased the building in which our corporate headquarters is located for an aggregate purchase price of $12.6 million. We financed a portion of the purchase price through an $8.0 million non-recourse mortgage loan arrangement. During 2004, we renewed this mortgage at the original principal amount of $8.0 million. The mortgage agreements bear interest at the prevailing prime rate less .25%. At December 31, 2004, our mortgages bore interest at 5.0%.

At December 31, 2004, we had working capital, defined as current assets less current liabilities, of $22.1 million as compared to $(18.5) million at December 31, 2003. Our working capital is sometimes negative due to our efforts to increase investment returns through purchases of investments that have maturities of greater than one year and, therefore, are classified as long-term. Our investment policies are also designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund working capital as needed.

Cash, cash equivalents and short-term investments were $178.4 million at December 31, 2004, and $79.5 million at December 31, 2003. Long-term investments were $139.0 million at December 31, 2004, and $205.2 million at December 31, 2003, including restricted deposits of $22.2 million and $20.4 million, respectively. Cash and investments held by our unregulated entities totaled $46.0 million and $126.7 million at December 31, 2004 and 2003, respectively.

In September 2004, we executed a five-year $100 million Revolving Credit Agreement with various financial institutions and LaSalle Bank National Association as administrative agent and arranger. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement is secured by the common stock and membership interests of our subsidiaries. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, minimum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2009 or on an earlier date in the instance of a default as defined in the agreement. In conjunction with this agreement, we cancelled our prior existing $50 million credit facility. As of December 31, 2004, we had $34 million outstanding under the agreement and were in compliance with all covenants.

In January 2005, we executed a definitive agreement, subject to regulatory approvals, to acquire the Medicaid-related assets of SummaCare, Inc. for approximately $31 million plus transaction costs. The purchase price will consist of approximately $22 million in cash and $9 million in common stock. The acquisition is expected to close in the second quarter of 2005.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our operations, the planned acquisition of SummaCare, Inc. and capital expenditures for at least 12 months from the date of this annual report.

Our principal contractual obligations at December 31, 2004, consisted of medical claims liabilities, borrowings from our credit facility and mortgages, operating leases and purchase obligations. The purchase obligations consist primarily of software purchase and maintenance contracts in addition to development agreements pertaining to our Montana claims facility and the future expansion of our corporate headquarters. The contractual obligations over the next five years and beyond are as follows (in thousands):

| | *Payments Due by Period* | | | | |
|---|---|---|---|---|---|
| | Total | Less than 1 year | 1 – 3 years | 3 – 5 years | More than 5 years |
| Medical claims liabilities | $165,980 | $165,980 | $ – | $ – | $ – |
| Debt | 47,459 | 486 | 972 | 34,972 | 11,029 |
| Operating leases | 33,521 | 6,766 | 11,244 | 7,898 | 7,613 |
| Purchase obligations | 9,049 | 2,805 | 3,919 | 75 | 2,250 |
| Total | $256,009 | $176,037 | $16,135 | $42,945 | $20,892 |

## Regulatory Capital and Dividend Restrictions

Our Medicaid Managed Care operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2004, our regulated subsidiaries had aggregate statutory capital and surplus of $123.6 million, compared with the required minimum aggregate statutory capital and surplus requirements of $65.1 million.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2004, our Indiana, Ohio, Texas and Wisconsin health plans were in compliance with risk-based capital requirements enacted in these states. If adopted by Kansas, Missouri or New Jersey, risk-based capital requirements may increase the minimum capital required for these subsidiaries. We continue to monitor the requirements in Kansas, Missouri and New Jersey and do not expect that they will have a material impact on our results of operations, financial position or cash flows. Acquisitions in new states or new markets in existing states may require additional capital funding for our regulated subsidiaries.

## Recent Accounting Pronouncements

In December 2004, SFAS No. 123 (revised 2004), "Share Based Payment," was issued. This Statement focuses primarily on accounting for transactions in which an entity obtains employee services in share-based payment transactions. This Statement requires public entities to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The grant date fair value of employee share options and similar instruments will be estimated using option-pricing models adjusted for the unique characteristics of those instruments. That cost will be recognized over the period during which an employee is required to provide service in exchange for the award. This Statement is required to be adopted by July 1, 2005. The effect of expensing stock options in accordance with the original SFAS No. 123 is presented in Note 3 of our Notes to Consolidated Financial Statements under the heading Stock Based Compensation included elsewhere in this annual report. After the adoption of SFAS No. 123 (revised 2004) the level of stock compensation expense may differ depending on the fair value method and assumptions utilized.

In January 2003, FASB Interpretation No. 46, "Consolidation of Variable Interest Entities, an Interpretation of ARB 51," was issued. The primary objectives of this interpretation, as amended, are to provide guidance on the identification and consolidation of variable interest entities, or VIEs, which are entities for which control is achieved through means other than through voting rights. We have completed an analysis of this Interpretation and have determined that we do not have any VIEs.

In November 2002, FASB Interpretation No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others an Interpretation of SFAS No. 5, 57, and 107 and Rescission of FASB Interpretation No. 34," was issued. This interpretation clarifies the requirements of SFAS No. 5, "Accounting for Contingencies," relating to a guarantor's accounting for, and disclosure of, the issuance of certain types of guarantees. The adoption of FASB Interpretation No. 45 did not have a significant impact on our net income or equity.

## Forward-Looking Statements

This annual report contains forward-looking statements that relate to future events or our future financial performance. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will," "should," "can," "continue" or the negative of these terms or other comparable terminology. These statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the sections of this annual report entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Business." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

Actual results may differ from projections or estimates due to a variety of important factors. Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in healthcare practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payers, major epidemics, disasters and numerous other factors affecting the delivery and cost of healthcare, such as major healthcare providers' inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation or suspension of our Medicaid managed care contracts by the state governments would also negatively affect us. Due to these factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

## Factors That May Affect Future Results and the Trading Price of Our Common Stock

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this annual report, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our company.

### Risks Related to Being a Regulated Entity

*Reduction in Medicaid, SCHIP and SSI Funding Could Substantially Reduce Our Profitability.*

Most of our revenues come from Medicaid, SCHIP and SSI premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, SCHIP and SSI funding and premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. For example, in August 2004, the Centers for Medicare & Medicaid Services, or CMS, proposed a rule requiring states to estimate improper payments made under their Medicaid and SCHIP programs, report such overpayments to Congress, and, if necessary, take actions to reduce erroneous payments. In February 2005, the Bush administration called for changes in Medicaid that would cut payments for prescription drugs and give states new power to reduce or reconfigure benefits. Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. Over the past two years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility. We believe that reductions in Medicaid, SCHIP and SSI payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

*If Our Medicaid and SCHIP Contracts are Terminated or are Not Renewed, Our Business Will Suffer.*

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, SSI and SCHIP. We provide

those healthcare services under contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between June 30, 2005 and August 31, 2007. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for two years and may be extended for one or two additional years if the state or its contractor elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

*Changes in Government Regulations Designed to Protect Providers and Members Rather Than Our Stockholders Could Force Us to Change How We Operate and Could Harm Our Business.*

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect health plan providers and members rather than stockholders. Changes in existing laws and rules, the enactment of new laws and rules or changing interpretations of these laws and rules could, among other things:

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;
- mandate minimum medical expense levels as a percentage of premiums revenues;
- restrict revenue and enrollment growth;
- require us to develop plans to guard against the financial insolvency of our providers;
- increase our healthcare and administrative costs;
- impose additional capital and reserve requirements; and
- increase or change our liability to members in the event of malpractice by our providers.

For example, Congress has considered various forms of patient protection legislation commonly known as the Patients' Bill of Rights and the legislation is frequently proposed in Congress. We cannot predict the impact of this legislation, if adopted, on our business.

*Regulations May Decrease the Profitability of Our Health Plans.*

Our Texas plan is required to pay a rebate to the state in the event profits exceed established levels. Similarly, our New Jersey plan is required to pay a rebate to the state in the event its health benefits ratio is less than 80%. These regulatory requirements, changes in these requirements or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits as a percentage of revenues. The states of Indiana, New Jersey and Texas have implemented prompt-payment laws and are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our operating results.

Also, on January 18, 2002, CMS published a final rule that removed a provision contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicaid payment principles. The upper payment limit was reduced to 100% of Medicare payments for comparable services. This development in federal regulation decreased the profitability of our health plans.

*Failure to Comply With Government Regulations Could Subject Us to Civil and Criminal Penalties.*

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SSI and SCHIP programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would negatively affect our ability to operate our business. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established

new enforcement mechanisms to combat fraud and abuse. Further, HIPAA imposes civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of most individually identifiable health information. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

*We Will Incur Significant Increased Costs As a Result of Compliance With New Government Regulations And Our Management Will Be Required to Devote Substantial Time To Compliance.*

On February 20, 2003, HHS published the final HIPAA health data security regulations. Compliance with the security regulations is required by April 21, 2005. These regulations will require covered entities to implement administrative, physical and technical safeguards to protect electronic health information maintained or transmitted by the organization.

The issuance of future judicial or regulatory guidance regarding the interpretation of regulations, the states' ability to promulgate stricter rules, and continuing uncertainty regarding many aspects of the regulations' implementation may make compliance with the relatively new regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with the new security regulations. In order to comply with the regulatory requirements, we will be required to employ additional or different programs and systems. Further, compliance with these regulations could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The new regulations and the related compliance costs could have a material adverse effect on our business.

In addition, the Sarbanes-Oxley Act, as well as rules subsequently implemented by the SEC and the New York Stock Exchange, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will need to devote a substantial amount of time to these new compliance initiatives. Moreover, these rules and regulations will increase our legal and financial compliance costs and will make some activities more time-consuming and costly.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will require that we incur substantial accounting expense and expend significant management efforts. Moreover, if we are not able to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

*Changes in Healthcare Law May Reduce Our Profitability.*

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible for Medicaid and reduce the reimbursement or payment levels for medical services. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare. Legislation or regulations that require us to change our current manner of operation, provide additional benefits or change our contract arrangements may seriously harm our operations and financial results.

*If a State Fails to Renew its Federal Waiver Application for Mandated Medicaid Enrollment into Managed Care or Such Application is Denied, Our Membership in That State Will Likely Decrease.*

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

*Changes in Federal Funding Mechanisms May Reduce Our Profitability.*

The Bush Administration has proposed a major long-term change in the way Medicaid and SCHIP are funded. The proposal, if adopted, would allow states to elect to receive, instead of federal matching funds, combined Medicaid-SCHIP "allotments" for acute and long-term healthcare for low-income, uninsured persons. Participating states would be given flexibility in designing their own health insurance programs, subject to federally-mandated minimum coverage requirements. It is uncertain whether this proposal will be enacted, or if so, how it may change from a similar proposal initiated by the Bush Administration in February 2003. Accordingly, it is unknown whether or how many states might elect to participate or how their participation may affect the net amount of funding available for Medicaid and SCHIP programs. If such a proposal is adopted and decreases the number of persons enrolled in Medicaid or SCHIP in the states in which we operate or reduces the volume of healthcare services provided, our growth, operations and financial performance could be adversely affected.

In April 2004, the Bush Administration adopted a new policy that seeks to reduce states' use of accounting devices such as intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers as part of states' Medicaid contributions, this policy, if continued, may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance.

In February 2005, the Bush Administration called for changes in Medicaid that would cut payments for prescription drugs and give states new power to reduce or reconfigure benefits. Any reduction or reconfiguration of state funding could adversely affect our growth, operations and financial performance.

Recent legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, enacted in December 2003, will, upon taking effect in 2006, revise cost-sharing requirements for some beneficiaries and require states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. These changes may reduce the availability of funding for some states' Medicaid programs, which could adversely affect our growth, operations and financial performance.

*If State Regulatory Agencies Require a Statutory Capital Level Higher than the State Regulations, We May Be Required to Make Additional Capital Contributions.*

Our operations are conducted through our wholly owned subsidiaries, which include HMOs and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

*If We Are Unable to Participate in SCHIP Programs, Our Growth Rate May be Limited.*

SCHIP is a federal initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. The programs vary significantly from state to state. Participation in SCHIP programs is an important part of our growth strategy. If states do not allow us to participate or if we fail to win bids to participate, our growth strategy may be materially and adversely affected.

*If State Regulators Do Not Approve Payments of Dividends and Distributions by Our Subsidiaries to Us, We May Not Have Sufficient Funds to Implement Our Business Strategy.*

We principally operate through our health plan subsidiaries. If funds normally available to us become limited in the future, we may need to rely on dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy.

## Risks Related to Our Business

*Receipt of Inadequate Premiums Would Negatively Affect Our Revenues and Profitability.*

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenues, to increase and our profits to decline. In addition, it is possible for a state to increase the

rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed.

*Failure to Effectively Manage Our Medical Costs or Related Administrative Costs Would Reduce Our Profitability.*

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Historically, our health benefits ratio has fluctuated. For example, over the last six years, our health benefits ratio has ranged from 80.7% to 88.9%. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. We may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

*Failure to Accurately Predict Our Medical Expenses Could Negatively Affect Our Reported Results.*

Our medical expenses include estimates of IBNR medical expenses. We estimate our IBNR medical expenses monthly based on a number of factors. Adjustments, if necessary, are made to medical expenses in the period during which the actual claim costs are ultimately determined or when criteria used to estimate IBNR change. We cannot be sure that our IBNR estimates are adequate or that adjustments to those estimates will not harm our results of operations. From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

*Difficulties in Executing Our Acquisition Strategy Could Adversely Affect Our Business.*

Historically, the acquisition of Medicaid businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. Many of the other potential purchasers of Medicaid assets have greater financial resources than we have. In addition, many of the sellers are interested either in (a) selling, along with their Medicaid assets, other assets in which we do not have an interest or (b) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot assure you that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities. Furthermore, our credit facility may prohibit some acquisitions without the consent of our bank lender.

In addition to the difficulties we may face in identifying and consummating acquisitions, we will also be required to integrate and consolidate any acquired business or assets with our existing operations. This may include the integration of:

- additional personnel who are not familiar with our operations and corporate culture;
- existing provider networks that may operate on different terms than our existing networks;
- existing members, who may decide to switch to another healthcare plan; and
- disparate administrative, accounting and finance, and information systems.

Accordingly, we may be unable to identify, consummate and integrate future acquisitions successfully or operate acquired businesses profitably. We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to execute our acquisition strategy effectively, our future growth will suffer and our results of operations could be harmed.

*If Competing Managed Care Programs are Unwilling to Purchase Specialty Services From Us, We May Not be Able to Successfully Implement Our Strategy of Diversifying Our Business Lines.*

We are seeking to diversify our business lines into areas that complement our Medicaid business in order to grow our revenue stream and balance our dependence on Medicaid risk reimbursement. In 2003, for example, we acquired Cenpatico Behavioral Health (formerly known as Group Practice Affiliates), a behavioral health services company, and purchased contract and name rights of ScriptAssist, a treatment compliance company. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our Medicaid programs. Our inability to market specialty services to other programs may impair our ability to execute our business strategy.

*Failure to Achieve Timely Profitability in Any Business Would Negatively Affect Our Results of Operations.*

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

*We Derive a Majority of Our Premium Revenues From Operations in a Small Number of States, and Our Operating Results Would be Materially Affected by a Decrease in Premium Revenues or Profitability in Any One of Those States.*

Operations in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin have accounted for most of our premium revenues to date. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative actions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

*Competition May Limit Our Ability to Increase Penetration of the Markets That We Serve.*

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs and mandated competition may limit our ability to increase our market share.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

*If We are Unable to Maintain Satisfactory Relationships With Our Provider Networks, Our Profitability Will be Harmed.*

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be cancelled by either party without cause upon 90 to 120 days prior written notice. We cannot assure you that we will be able to continue to renew our existing contracts or enter into new contracts enabling us to service our members profitably.

From time to time providers assert or threaten to assert claims seeking to terminate noncancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms.

If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

*Changes in Stock Option Accounting Rules May Have a Significant Adverse Affect on Our Operating Results.*

We have a history of using broad based employee stock option programs to hire, incentivize and retain our workforce in a competitive marketplace. Statement of Financial Accounting Standards No. 123, "Accounting for Stock-Based Compensation," allows companies the choice of either using a fair value method of accounting for options that would result in expense recognition for all options granted, or using an intrinsic value method, as prescribed by Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees," or APB 25, with a pro forma disclosure of the impact on net income (loss) of using the fair value option expense recognition method. We have previously elected to apply APB 25 and accordingly we generally have not recognized any expense with respect to employee stock options as long as such options are granted at exercise prices equal to the fair value of our common stock on the date of grant.

In December 2004, the Financial Accounting Standards Board issued SFAS No. 123 (revised 2004), "Share Based Payment," which would require all companies to measure compensation cost for all share-based payments, including employee stock options, at fair value. This statement is effective for public companies for interim or annual periods beginning after June 15, 2005. We are currently evaluating the effect that the adoption of this Statement will have on our financial position and results of operations. We believe, however, that our adoption of this standard will adversely affect our operating results in future periods.

*We May be Unable to Attract and Retain Key Personnel.*

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and operating results could be harmed. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

*Negative Publicity Regarding the Managed Care Industry May Harm Our Business and Operating Results.*

The managed care industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services, and increase the regulatory burdens under which we operate. Any of these factors may increase the costs of doing business and adversely affect our operating results.

*Claims Relating to Medical Malpractice Could Cause Us to Incur Significant Expenses.*

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states, including Texas, have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

*Loss of Providers Due to Increased Insurance Costs Could Adversely Affect Our Business.*

Our providers routinely purchase insurance to help protect themselves against medical malpractice claims. In recent years, the costs of maintaining commercially reasonable levels of such insurance have increased dramatically, and these costs are expected to increase to even greater levels in the

future. As a result of the level of these costs, providers may decide to leave the practice of medicine or to limit their practice to certain areas, which may not address the needs of Medicaid participants. We rely on retaining a sufficient number of providers in order to maintain a certain level of service. If a significant number of our providers exit our provider networks or the practice of medicine generally, we may be unable to replace them in a timely manner, if at all, and our business could be adversely affected.

*Growth in the Number of Medicaid-Eligible Persons During Economic Downturns Could Cause Our Operating Results and Stock Prices to Suffer if State and Federal Budgets Decrease or Do Not Increase.*

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

*Growth in the Number of Medicaid-Eligible Persons May be Countercyclical, Which Could Cause Our Operating Results to Suffer When General Economic Conditions are Improving.*

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. Conversely, this number may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels to decrease, thereby causing our operating results to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

*We Intend to Expand Our Medicaid Managed Care Business Primarily into Markets Where Medicaid Recipients are Required to Enroll in Managed Care Plans.*

We expect to continue to focus our business in states in which Medicaid enrollment in managed care is mandatory. Currently, approximately two-thirds of the states require health plan enrollment for Medicaid eligible participants in all or a portion of their counties. The programs are voluntary in other states. Because we concentrate on markets with mandatory enrollment, we expect the geographic expansion of our Medicaid Managed Care segment to be limited to those states.

*If We are Unable to Integrate and Manage Our Information Systems Effectively, Our Operations Could be Disrupted.*

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. Moreover, our acquisition activity requires frequent transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

*We Rely on the Accuracy of Eligibility Lists Provided by State Governments. Inaccuracies in Those Lists Would Negatively Affect Our Results of Operations.*

Premium payments to us are based upon eligibility lists produced by state governments. From time-to-time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

*We May Not be Able to Obtain or Maintain Adequate Insurance.*

We maintain liability insurance, subject to limits and deductibles, for claims that could result from providing or failing to provide managed care and related services. These claims could be substantial. We believe that our present insurance coverage and reserves are adequate to cover currently estimated exposures. We cannot assure you that we will be able to obtain adequate insurance coverage in the future at acceptable costs or that we will not incur significant liabilities in excess of policy limits.

# Quantitative and Qualitative Disclosures About Market Risk

## Investments

As of December 31, 2004, we had short-term investments of $94.3 million and long-term investments of $139.0 million, including restricted deposits of $22.2 million. The short-term investments consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Agency bonds, life insurance contracts and U.S. Treasury investments and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Restricted deposits are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2004, the fair value of our fixed income investments would decrease by approximately $4.1 million. Declines in interest rates over time will reduce our investment income.

## Inflation

Although the general rate of inflation has remained relatively stable and healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

## Compliance Costs

Federal and state regulations governing standards for electronic transactions, data security and confidentiality of patient information have been issued recently. Due to the uncertainty surrounding the regulatory requirements, we cannot be sure that the systems and programs that we have implemented will comply adequately with the regulations that are ultimately adopted. Implementation of additional systems and programs may be required. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover our costs of complying with these new regulations from the states.

# Consolidated Balance Sheets

| *(In thousands, except share data)* | *December 31,* 2004 | 2003 |
|---|---|---|
| **Assets** | | |
| Current assets: | | |
| Cash and cash equivalents | **$ 84,105** | $ 64,346 |
| Premium and related receivables, net of allowances of $462 and $607, respectively | **31,475** | 20,308 |
| Short-term investments, at fair value (amortized cost $94,442 and $15,192, respectively) | **94,283** | 15,160 |
| Other current assets | **14,429** | 10,487 |
| Total current assets | **224,292** | 110,301 |
| Long-term investments, at fair value (amortized cost $117,177 and $183,749, respectively) | **116,787** | 184,811 |
| Restricted deposits, at fair value (amortized cost $22,295 and $20,201, respectively) | **22,187** | 20,364 |
| Property, software and equipment | **43,248** | 23,106 |
| Goodwill | **101,631** | 13,066 |
| Other intangible assets | **14,439** | 6,294 |
| Other assets | **5,350** | 4,750 |
| Total assets | **$527,934** | $362,692 |
| **Liabilities and Stockholders' Equity** | | |
| Current liabilities: | | |
| Medical claims liabilities | **$165,980** | $106,569 |
| Accounts payable and accrued expenses | **31,737** | 17,965 |
| Unearned revenue | **3,956** | 3,673 |
| Current portion of long-term debt and notes payable | **486** | 579 |
| Total current liabilities | **202,159** | 128,786 |
| Long-term debt | **46,973** | 7,616 |
| Other liabilities | **7,490** | 6,175 |
| Total liabilities | **256,622** | 142,577 |
| Stockholders' equity: | | |
| Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 41,316,122 and 40,263,848 shares, respectively | **41** | 40 |
| Additional paid-in capital | **165,391** | 157,360 |
| Accumulated other comprehensive income: | | |
| Unrealized (loss) gain on investments, net of tax | **(407)** | 740 |
| Retained earnings | **106,287** | 61,975 |
| Total stockholders' equity | **271,312** | 220,115 |
| Total liabilities and stockholders' equity | **$527,934** | $362,692 |

*See notes to consolidated financial statements.*

# Consolidated Statements of Earnings

| *(In thousands, except share data)* | *Year Ended December 31,* 2004 | 2003 | 2002 |
|---|---|---|---|
| Revenues: | | | |
| Premiums | $ 991,673 | $759,763 | $461,030 |
| Services | 9,267 | 9,967 | 457 |
| Total revenues | 1,000,940 | 769,730 | 461,487 |
| Expenses: | | | |
| Medical costs | 800,476 | 626,192 | 379,468 |
| Cost of services | 8,065 | 8,323 | 341 |
| General and administrative expenses | 127,863 | 88,288 | 50,072 |
| Total operating expenses | 936,404 | 722,803 | 429,881 |
| Earnings from operations | 64,536 | 46,927 | 31,606 |
| Other income (expense): | | | |
| Investment and other income | 6,431 | 5,160 | 9,575 |
| Interest expense | (680) | (194) | (45) |
| Earnings before income taxes | 70,287 | 51,893 | 41,136 |
| Income tax expense | 25,975 | 19,504 | 15,631 |
| Minority interest | – | 881 | 116 |
| Net earnings | $ 44,312 | $ 33,270 | $ 25,621 |
| Earnings per share: | | | |
| Basic earnings per common share | $ 1.09 | $ 0.93 | $ 0.82 |
| Diluted earnings per common share | $ 1.02 | $ 0.87 | $ 0.73 |
| Weighted average number of shares outstanding: | | | |
| Basic | 40,820,909 | 35,704,426 | 31,432,080 |
| Diluted | 43,616,445 | 38,422,152 | 34,932,232 |

*See notes to consolidated financial statements.*

# Consolidated Statements of Stockholders' Equity

| *(In thousands, except share data)* | Common Stock $.001 Par Value Shares | Common Stock Amt | Additional Paid-in Capital | Unrealized Gain (Loss) on Investments | Retained Earnings | Total |
|---|---|---|---|---|---|---|
| **Balance**, December 31, 2001 | 30,255,336 | $30 | $ 60,837 | $ 135 | $ 3,087 | $ 64,089 |
| Net earnings | – | – | – | – | 25,621 | 25,621 |
| Change in unrealized investment gains, net of $559 tax | – | – | – | 952 | – | 952 |
| Comprehensive earnings | | | | | | 26,573 |
| Common stock issued for stock options and employee stock purchase plan | 820,476 | 1 | 490 | – | – | 491 |
| Proceeds from stock offering | 1,411,486 | 1 | 10,317 | – | – | 10,318 |
| Stock compensation expense | – | – | 270 | – | – | 270 |
| Tax benefits related to stock options | – | – | 442 | – | – | 442 |
| **Balance**, December 31, 2002 | 32,487,298 | $32 | $ 72,356 | $ 1,087 | $ 28,708 | $102,183 |
| Net earnings | – | – | – | – | 33,270 | 33,270 |
| Change in unrealized investment gains, net of $(186) tax | – | – | – | (347) | – | (347) |
| Comprehensive earnings | | | | | | 32,923 |
| Common stock issued for stock options and employee stock purchase plan | 876,550 | 1 | 1,144 | – | – | 1,145 |
| Proceeds from stock offering | 6,900,000 | 7 | 81,306 | – | – | 81,313 |
| Stock compensation expense | – | – | 188 | – | – | 188 |
| Tax benefits related to stock options | – | – | 2,366 | – | – | 2,366 |
| Cash paid for fractional share impact of stock split | – | – | – | – | (3) | (3) |
| **Balance**, December 31, 2003 | 40,263,848 | $40 | $157,360 | $ 740 | $ 61,975 | $220,115 |
| Net earnings | – | – | – | – | 44,312 | 44,312 |
| Change in unrealized investment gains, net of $(703) tax | – | – | – | (1,147) | – | (1,147) |
| Comprehensive earnings | | | | | | 43,165 |
| Common stock issued for stock options and employee stock purchase plan | 1,052,274 | 1 | 4,065 | – | – | 4,066 |
| Stock compensation expense | – | – | 650 | – | – | 650 |
| Tax benefits related to stock options | – | – | 3,316 | – | – | 3,316 |
| **Balance, December 31, 2004** | **41,316,122** | **$41** | **$165,391** | **$ (407)** | **$106,287** | **$271,312** |

*See notes to consolidated financial statements.*

# Consolidated Statements of Cash Flows

| *(In thousands)* | *Years Ended December 31,* 2004 | 2003 | 2002 |
|---|---|---|---|
| **Cash flows from operating activities:** | | | |
| Net earnings | **$ 44,312** | $ 33,270 | $ 25,621 |
| Adjustments to reconcile net earnings to net cash provided by operating activities – | | | |
| Depreciation and amortization | **10,014** | 6,448 | 2,565 |
| Tax benefits related to stock options | **3,316** | 2,366 | 442 |
| Stock compensation expense | **650** | 188 | 270 |
| Minority interest | **–** | (881) | (116) |
| Gain on sale of investments | **(138)** | (1,646) | (649) |
| Tax benefits of pre-acquisition net operating losses | **3,295** | – | – |
| Changes in assets and liabilities – | | | |
| Premium and related receivables | **(425)** | (2,364) | (2,449) |
| Other current assets | **(786)** | (3,180) | (1,463) |
| Deferred income taxes | **(1,638)** | 772 | (574) |
| Other assets | **(728)** | 223 | 857 |
| Medical claims liabilities | **34,501** | 15,053 | 15,386 |
| Unearned revenue | **283** | 3,673 | (827) |
| Accounts payable and accrued expenses | **6,483** | 1,531 | 1,468 |
| Other operating activities | **266** | 546 | (872) |
| Net cash provided by operating activities | **99,405** | 55,999 | 39,659 |
| **Cash flows from investing activities:** | | | |
| Purchase of property, software and equipment | **(25,009)** | (19,162) | (3,918) |
| Purchase of investments | **(254,358)** | (435,282) | (192,371) |
| Sales and maturities of investments | **243,623** | 319,564 | 127,706 |
| Acquisitions, net of cash acquired | **(86,739)** | (5,861) | (11,096) |
| Net cash used in investing activities | **(122,483)** | (140,741) | (79,679) |
| **Cash flows from financing activities:** | | | |
| Proceeds from issuance of common stock | **–** | 81,313 | 10,318 |
| Proceeds from exercise of stock options | **4,066** | 1,145 | 491 |
| Proceeds from borrowings | **45,860** | 8,581 | – |
| Reduction of long-term debt and notes payable | **(6,596)** | (386) | – |
| Other financing activities | **(493)** | (1,221) | – |
| Net cash provided by financing activities | **42,837** | 89,432 | 10,809 |
| Net increase (decrease) in cash and cash equivalents | **19,759** | 4,690 | (29,211) |
| Cash and cash equivalents, beginning of period | **64,346** | 59,656 | 88,867 |
| Cash and cash equivalents, end of period | **$ 84,105** | $ 64,346 | $ 59,656 |
| Interest paid | **$ 494** | $ 176 | $ 28 |
| Income taxes paid | **$ 20,518** | $ 19,935 | $ 16,433 |

*See notes to consolidated financial statements.*

## 1. Organization and Operations

Centene Corporation (Centene or the Company) provides multi-line managed care programs and related services to individuals receiving benefits under government subsidized programs including Medicaid, Supplemental Security Income (SSI), and the State Children's Health Insurance Program (SCHIP). Centene's Medicaid Managed Care segment operates under its own state licenses in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin, and contracts with other managed care organizations to provide risk and non-risk management services. Centene's Specialty Services segment contracts with Centene-owned companies, as well as other healthcare organizations, to provide specialty services including behavioral health, nurse triage and treatment compliance.

In November 2004, the Company declared a two-for-one stock split effected in the form of a 100% stock dividend, payable December 17, 2004, to shareholders of record on November 24, 2004. In May 2004, the Company's stockholders approved an increase in the authorized shares of common stock to 100,000,000 shares.

In May 2003, the Company declared a three-for-two stock split effected in the form of a 50% stock dividend, payable July 11, 2003 to shareholders of record on June 20, 2003. All share, per share and stockholders' equity amounts have been restated to reflect these stock splits and the increase in authorized shares.

## 2. Public Stock Offerings

In August 2003, the Company closed a follow-on public offering of 6,900,000 shares of common stock at $12.50 per share. Centene received net proceeds of $81,313 from this offering.

In June 2002, the Company closed a follow-on public offering whereby 15,838,516 shares were sold by selling stockholders and 1,411,486 shares were sold by the Company at $8.25 per share. Centene received net proceeds of $10,318 from this offering.

## 3. Summary of Significant Accounting Policies

### Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries. All material intercompany balances and transactions have been eliminated.

### Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

### Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of commercial paper, money market funds, repurchase agreements and bank savings accounts.

### Investments

Short-term investments include securities with maturities between three months and one year. Long-term investments include securities with maturities greater than one year.

Short-term and long-term investments are classified as available for sale and are carried at fair value based on quoted market prices. Unrealized gains and losses on investments available for sale are excluded from earnings and reported as a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

### Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

### Property, Software and Equipment

Property, software and equipment is stated at cost less accumulated depreciation. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and

services and payroll costs of employees devoted to specific software development. Depreciation is calculated principally by the straight-line method over estimated useful lives ranging from 40 years for buildings, three to five years for software and computer equipment and five to seven years for furniture and equipment. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease ranging between one and ten years.

### Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist of non-compete agreements, purchased contract rights, provider contracts and goodwill. Purchased contract rights are amortized using the straight-line method over periods ranging from 60 to 120 months. Provider contracts are amortized using the straight-line method over 120 months.

Goodwill is reviewed at each year-end for impairment. In addition, the Company will perform an impairment analysis of other intangible assets based on other factors. Such factors would include, but are not limited to, significant changes in membership, state funding, medical contracts and provider networks and contracts. An impairment loss is recognized if the carrying value of goodwill exceeds the implied fair value. The Company did not recognize any impairment losses for the periods presented.

### Medical Claims Liabilities

Medical services costs include claims paid, claims adjudicated but not yet paid, estimates for claims received but not yet adjudicated, estimates for claims incurred but not yet received and estimates for the costs necessary to process unpaid claims.

The estimates of medical claims liabilities are developed using standard actuarial methods based upon historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors including product changes. These estimates are continually reviewed and adjustments, if necessary, are reflected in the period known. Management did not change actuarial methods during the years presented. Management believes the amount of medical claims payable is reasonable and adequate to cover the Company's liability for unpaid claims as of December 31, 2004; however, actual claim payments may differ from established estimates.

### Revenue Recognition

The majority of the Company's Medicaid Managed Care premium revenue is received monthly based on fixed rates per member as determined by state contracts. Some contracts allow for additional premium related to certain supplemental services provided such as maternity deliveries. Revenue is recognized as earned over the covered period of services. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this membership and eligibility data. These adjustments are immaterial in relation to total revenue recorded and are reflected in the period known. Premiums collected in advance are recorded as unearned revenue.

The Specialty Services segment generates revenue from capitation payments to our behavioral health company from our health plans and others. It also receives fees for the direct provision of care and school programs in Arizona. The Company's treatment compliance program receives fee income from the manufacturers of pharmaceuticals. The Company's nurse line product receives fees from health plans, physicians and other organizations for providing continuous access to nurse advisors.

Revenues due to the Company are recorded as premium and related receivables and recorded net of an allowance for uncollectible accounts based on historical trends and management's judgment on the collectibility of these accounts.

### Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The contracts, which expire on various dates between June 30, 2005 and August 31, 2007, are expected to be renewed. Contracts with the states of Indiana, New Jersey, Texas and Wisconsin each accounted for over 10% of the Company's revenues for the year ended December 31, 2004.

### Reinsurance

Centene's Medicaid Managed Care subsidiaries have purchased reinsurance from third parties to cover eligible healthcare services. The current reinsurance agreements generally cover 90% of inpatient healthcare expenses in excess of annual deductibles of $75 to $200 per member, up to a lifetime maximum of $2,000. The subsidiaries are responsible for inpatient charges in excess of an average daily per diem.

Reinsurance recoveries were $3,730, $5,345 and $1,542 in 2004, 2003 and 2002, respectively. Reinsurance expenses were approximately $6,724, $6,185 and $3,981 in 2004, 2003 and 2002, respectively. Reinsurance recoveries, net of expenses, are included in medical costs.

### Other Income (Expense)

Other income (expense) consists principally of investment income and interest expense. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. For the year ended December 31, 2002, investment income included a $5,100 one-time dividend from a captive insurance company in which the Company maintained an investment.

Interest expense consists of borrowings under our credit facility, mortgage interest and credit facility fees.

### Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date of the tax rate change.

### Stock Based Compensation

The Company accounts for stock based compensation plans in accordance with the intrinsic value based method of Accounting Principles Board Opinion No. 25. Compensation cost related to stock options issued to employees is calculated on the date of grant only if the current market price of the underlying stock exceeds the exercise price. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally five years for stock options and five to ten years for restricted stock unit awards. The Company recognized $650, $188 and $270 during the years ended December 31, 2004, 2003 and 2002, respectively, for stock based compensation expense. Had compensation cost for the plans been determined based on the fair value method at the grant dates as specified in SFAS No. 123, the Company's net earnings would have been reduced to the following pro forma amounts:

| | 2004 | 2003 | 2002 |
|---|---|---|---|
| Net earnings | **$44,312** | $33,270 | $25,621 |
| Pro forma stock-based employee compensation expense determined under fair value based method, net of related tax effects | **3,490** | 2,261 | 1,556 |
| Pro forma net earnings | **$40,822** | $31,009 | $24,065 |
| Basic earnings per common share: | | | |
| As reported | **$ 1.09** | $ 0.93 | $ 0.82 |
| Pro forma | **1.00** | 0.87 | 0.77 |
| Diluted earnings per common share: | | | |
| As reported | **$ 1.02** | $ 0.87 | $ 0.73 |
| Pro forma | **0.94** | 0.81 | 0.69 |

Additional information regarding the stock option plans is included in Note 14.

### Reclassifications

Certain amounts in the consolidated financial statements have been reclassified to conform to the 2004 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

### Recent Accounting Pronouncements

In December 2004, SFAS No. 123 (revised 2004), "Share Based Payment," was issued. This Statement focuses primarily on accounting for transactions in which an entity obtains employee services in share-based payment transactions. This Statement requires public entities to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The grant-date fair value of employee share options and similar instruments will be estimated using option-pricing models adjusted for the unique characteristics of those instruments. That cost will be recognized over the period during which an employee is required to provide service in exchange for the award. This Statement is required to be adopted by the Company by July 1, 2005. The effect of expensing stock options in accordance with the original SFAS No. 123 is presented above under the heading Stock Based Compensation. After the adoption of SFAS No. 123 (revised 2004) the level of stock compensation expense may differ depending on the fair value method and assumptions utilized.

In January 2003, FASB Interpretation No. 46, "Consolidation of Variable Interest Entities, an Interpretation of ARB 51," was issued. The primary objectives of this interpretation, as amended, are to provide guidance on the identification and consolidation of variable interest entities (VIEs) which are entities for which control is achieved through means other than through voting rights. The Company has completed an analysis of this Interpretation and has determined that it does not have any VIEs.

In November 2002, FASB Interpretation No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others an Interpretation of SFAS No. 5, 57, and 107 and Rescission of FASB Interpretation No. 34," was issued. This interpretation clarifies the requirements of SFAS No. 5, "Accounting for Contingencies," relating to a guarantor's accounting for, and disclosure of, the issuance of certain types of guarantees. The adoption of FASB Interpretation No. 45 did not have a significant impact on the net income or equity of the Company.

## 4. Acquisitions

### SummaCare

In January 2005, the Company announced a definitive agreement to acquire the Medicaid-related assets in Ohio of SummaCare, Inc. The purchase price of approximately $31,000 plus transaction costs will be allocated to the assets acquired and liabilities assumed according to estimated fair values. This transaction is anticipated to close in the second quarter of 2005 subject to regulatory approvals.

### FirstGuard

The Company purchased FirstGuard Inc. and FirstGuard Health Plan, Inc. from Swope Community Enterprises (Swope) effective December 1, 2004. FirstGuard Inc.'s subsidiary, FirstGuard Health Plan Kansas, serves approximately 94,000 Medicaid and SCHIP members throughout the state of Kansas and FirstGuard Health Plan, Inc. serves approximately 41,000 Medicaid members in Missouri (collectively, FirstGuard). Prior to our acquisition of FirstGuard, FirstGuard, Inc. acquired the 20% interest in FirstGuard Health Plan Kansas, Inc. held by a third-party. Swope has indemnified Centene with respect to any claims arising out of the purchase of the 20% interest. Centene paid approximately $96,133 in cash and transaction costs. In accordance with terms in the agreement, the purchase price may be adjusted on certain conditions up to sixteen months after the acquisition date. The results of operations for FirstGuard are included in the consolidated financial statements since December 1, 2004.

The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $91,756. We have preliminarily allocated the excess purchase price over the fair value of the net tangible assets acquired to identifiable intangible assets of $8,000 and associated deferred tax liabilities of $3,040 and goodwill of approximately $86,796. The identifiable intangible assets have an estimated useful life of 10 years. The acquired goodwill is not deductible for income tax purposes. Our preliminary estimate of the fair value of the tangible assets/(liabilities) as of the acquisition date, which is subject to further refinement, is as follows:

| | |
|---|---|
| Cash, cash equivalents and investments | $ 51,004 |
| Premium and related receivables and other current assets | 13,511 |
| Property, software and equipment | 292 |
| Medical claims liabilities | (24,909) |
| Accounts payable and accrued expenses | (7,235) |
| Due to seller | (28,286) |
| Net tangible assets acquired | $ 4,377 |

The following unaudited pro forma information presents the results of operations of Centene and subsidiaries as if the FirstGuard acquisition described above had occurred at the beginning of each period presented. These pro forma results may not necessarily reflect the actual results of operations that would have been achieved, nor are they necessarily indicative of future results of operations.

| | 2004 | 2003 |
|---|---|---|
| Revenue | $1,222,396 | $1,003,107 |
| Net earnings | 51,466 | 46,409 |
| Diluted net earnings per share | $ 1.18 | $ 1.21 |

### Family Health Plan

Effective January 1, 2004, the Company commenced operations in Ohio through the acquisition from Family Health Plan, Inc. of certain Medicaid-related assets for a purchase price of approximately $6,864. The cost to acquire the Medicaid-related assets has been allocated to the assets acquired and liabilities assumed according to estimated fair values.

The purchase price allocation resulted in identified intangible assets of $1,800, representing purchased contract rights, provider network and a non-compete agreement. The intangibles are being amortized over periods ranging from five to ten years. In addition, goodwill approximated $5,064 which is deductible for tax purposes.

### HMO Blue Texas

Effective August 1, 2003, the Company acquired certain Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market for $1,045. The purchase price was allocated to acquired contracts, which are being amortized on a straight-line basis over a period of five years, the expected period of benefit.

### Cenpatico Behavioral Health

During 2003, the Company acquired a 100% ownership interest in Group Practice Affiliates, LLC, a behavioral healthcare services company (63.7% in March 2003 and 36.3% in August 2003). In September 2004, the Company renamed the subsidiary Cenpatico Behavioral Health, LLC (Cenpatico). The consolidated financial statements include the results of operations of Cenpatico since March 1, 2003. The Company paid $1,800 and assumed net liabilities of approximately $1,939 for its purchase of Cenpatico. The cost to acquire the ownership interest has been allocated to the assets acquired and liabilities assumed according to estimated fair values. The allocation has resulted in goodwill of approximately $3,739. The goodwill is not deductible for tax purposes.

### ScriptAssist

In March 2003, the Company purchased contract and name rights of ScriptAssist, LLC (ScriptAssist), a treatment compliance company. The purchase price of $563 was allocated to acquired contracts, which are being amortized on a straight-line basis over a period of five years, the expected period of benefit. The investor group who held membership interests in ScriptAssist included one of the Company's executive officers.

### University Health Plans

On December 1, 2002, the Company purchased 80% of the outstanding capital stock of University Health Plans, Inc. (UHP) in New Jersey. In October 2003, the Company exercised its option to purchase the remaining 20% of the outstanding capital stock. Centene paid a total purchase price of $13,258. The results of operations for UHP are included in the consolidated financial statements since December 1, 2002.

The acquisition of UHP resulted in identified intangible assets of $3,800, representing purchased contract rights and provider network. The intangibles are being amortized over a ten-year period. Goodwill of $5,027 is not deductible for tax purposes. Changes during 2003 to the preliminary purchase price allocation primarily consisted of the purchase of the remaining 20% of the outstanding stock and the recognition of intangible assets and related deferred tax liabilities.

The following unaudited pro forma information presents the results of operations of Centene and subsidiaries as if the UHP acquisition described above had occurred as of January 1, 2002. These pro forma results may not necessarily reflect the actual results of operations that would have been achieved, nor are they necessarily indicative of future results of operations.

| | 2002 |
|---|---|
| Revenue | $567,048 |
| Net earnings | 25,869 |
| Diluted net earnings per share | $ 0.74 |

### Texas Universities Health Plan

In June 2002, the Company purchased SCHIP contracts in three Texas service areas. The cash purchase price of $595 was recorded as purchased contract rights, which are being amortized on a straight-line basis over five years, the expected period of benefit.

### Bankers Reserve

In March 2002, the Company acquired Bankers Reserve Life Insurance Company of Wisconsin for a cash purchase price of $3,527. The Company allocated the purchase price to net tangible and identifiable intangible assets based on their fair value. Centene allocated $306 to identifiable intangible assets, representing the value assigned to acquired licenses, which are being amortized on a straight-line basis over a period of ten years. The Company accounted for this acquisition under the purchase method of accounting and accordingly, the consolidated results of operations include the results of the acquired Bankers Reserve business from the date of acquisition. Pro forma disclosures related to the acquisition have been excluded as immaterial.

As part of the acquisition, the Company acquired $5,200 of Separate Account assets and $5,200 of Separate Account liabilities. The acquired Separate Account assets and liabilities represent fixed rate annuity contracts with various maturity dates. Concurrent with the acquisition of Bankers Reserve, the Company entered into a 100% coinsurance reinsurance agreement with an unaffiliated party to reinsure the guaranteed cash value, annuity benefit, surrender benefit and death benefits associated with these contracts. The reinsurance premiums paid for this coverage equal the net administrative fee earned and received by the Company on the annuity contracts. Accordingly, there is no income statement impact to the Company as a result of acquiring the Separate Account assets and liabilities. The Separate Account balances, which are being liquidated and paid to insureds as annuities mature, do not have a minimum guarantee benefit beyond the cash surrender value of the policy. At December 31, 2004 Separate Account balances of $3,547 are included in Other assets and Other liabilities in the consolidated balance sheets.

## 5. Short-term and Long-term Investments and Restricted Deposits

Short-term and long-term investments and restricted deposits available for sale by investment type at December 31, 2004 consist of the following:

| | *December 31, 2004* | | | |
|---|---|---|---|---|
| | Amortized Cost | Gross Unrealized Gains | Gross Unrealized Losses | Estimated Market Value |
| U.S. Treasury securities and obligations of U.S. government corporations and agencies | $ 53,171 | $104 | $ (317) | $ 52,958 |
| Corporate securities | 97,958 | 77 | (473) | 97,562 |
| State and municipal securities | 71,428 | 294 | (335) | 71,387 |
| Asset backed securities | 3,156 | – | (7) | 3,149 |
| Life insurance contracts | 8,201 | – | – | 8,201 |
| Total | $233,914 | $475 | $(1,132) | $233,257 |

Substantially all of the investments in a gross unrealized loss position at December 31, 2004 have been in an unrealized loss position for less than 12 months. These investments had an estimated market value of $164,318 and amortized cost of $165,450 at December 31, 2004. The Company monitors these investments for other than temporary impairment. These investments have experienced a decline in value due to changes in market interest rates. Based on the credit quality of the investments and our intent and ability to hold these investments to recovery (which may be maturity), no other than temporary impairment has been recorded.

Short-term and long-term investments and restricted deposits available for sale by investment type at December 31, 2003 consist of the following:

| | *December 31, 2003* | | | |
|---|---|---|---|---|
| | Amortized Cost | Gross Unrealized Gains | Gross Unrealized Losses | Estimated Market Value |
| U.S. Treasury securities and obligations of U.S. government corporations and agencies | $ 19,570 | $ 163 | $ – | $ 19,733 |
| State and municipal securities | 198,695 | 1,344 | (314) | 199,725 |
| Corporate securities | 877 | – | – | 877 |
| Total | $219,142 | $1,507 | $(314) | $220,335 |

The contractual maturity of short-term and long-term investments and restricted deposits as of December 31, 2004, are as follows:

| | Investments | | Restricted Deposits | |
|---|---|---|---|---|
| | Amortized Cost | Estimated Market Value | Amortized Cost | Estimated Market Value |
| One year or less | $ 94,442 | $ 94,283 | $ 6,876 | $ 6,846 |
| One year through five years | 95,500 | 95,083 | 14,591 | 14,476 |
| Five years through ten years | 21,677 | 21,704 | 828 | 865 |
| Total | $211,619 | $211,070 | $22,295 | $22,187 |

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed securities are included in the one year through five years category, and life insurance contracts are included in the five years through ten years category.

The Company recorded realized gains and losses on the sale of investments for the years ended December 31 as follows:

| | 2004 | 2003 | 2002 |
|---|---|---|---|
| Gross realized gains | $ 861 | $1,859 | $698 |
| Gross realized losses | (723) | (213) | (49) |
| Net realized gains | $ 138 | $1,646 | $649 |

Various state statutes require the Company's managed care subsidiaries to deposit or pledge minimum amounts of investments to state agencies. Securities with a fair market value of $22,187 and $20,364 were deposited or pledged to state agencies by Centene's managed care subsidiaries at December 31, 2004 and 2003, respectively. These investments are classified as long-term restricted deposits in the consolidated financial statements due to the nature of the states' requirements.

## 6. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31:

| | 2004 | 2003 |
|---|---|---|
| Building | $ 13,649 | $10,971 |
| Land | 13,129 | 2,320 |
| Computer software | 10,976 | 4,878 |
| Computer hardware | 7,052 | 4,311 |
| Furniture and office equipment | 6,197 | 5,330 |
| Leasehold improvements | 4,321 | 3,663 |
| | 55,324 | 31,473 |
| Less — accumulated depreciation | (12,076) | (8,367) |
| Property, software and equipment, net | $ 43,248 | $23,106 |

Depreciation expense for the years ended December 31, 2004, 2003 and 2002 was $5,149, $3,469 and $1,887, respectively.

## 7. Intangible Assets

Goodwill balances and the changes therein are as follows:

| | Medicaid Managed Care | Specialty Services | Total |
|---|---|---|---|
| Balance as of December 31, 2002 | $ 5,022 | $ – | $ 5,022 |
| Acquisitions | 2,628 | 3,895 | 6,523 |
| Purchase price allocation adjustments | 1,521 | – | 1,521 |
| Balance as of December 31, 2003 | 9,171 | 3,895 | 13,066 |
| Acquisitions | 91,860 | – | 91,860 |
| Purchase price allocation adjustments | (3,140) | (155) | (3,295) |
| Balance as of December 31, 2004 | $97,891 | $3,740 | $101,631 |

Purchase price allocation adjustments in 2004 were related to the realization of the tax benefits of pre-acquisition net operating loss carryforward amounts.

Other intangible assets at December 31 consist of the following:

| | 2004 | 2003 | Weighted Average Life in Years 2004 | Weighted Average Life in Years 2003 |
|---|---|---|---|---|
| Purchased contract rights | $ 7,318 | $ 6,492 | 7.2 | 7.9 |
| Provider contracts | 1,900 | 1,400 | 10.0 | 10.0 |
| Non-compete agreements | 300 | – | 5.0 | – |
| Estimated FirstGuard identifiable intangibles | 8,000 | – | 10.0 | – |
| Other intangible assets | 17,518 | 7,892 | 7.8 | 8.3 |
| Less accumulated amortization | | | | |
| Purchased contract rights | (2,611) | (1,446) | | |
| Provider contracts | (342) | (152) | | |
| Non-compete agreements | (60) | – | | |
| Estimated FirstGuard identifiable intangibles | (66) | – | | |
| Total accumulated amortization | (3,079) | (1,598) | | |
| Other intangible assets, net | $14,439 | $ 6,294 | | |

Amortization expense was $1,481, $986 and $367 for the years ended December 31, 2004, 2003 and 2002, respectively. The estimated amortization expense for 2005, 2006, 2007, 2008 and 2009 is approximately $2,200, $2,000, $1,900, $1,600 and $1,300, respectively.

## 8. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31:

| | 2004 | 2003 | 2002 |
|---|---|---|---|
| Current: | | | |
| Federal | $23,652 | $16,776 | $13,661 |
| State | 3,038 | 2,464 | 2,338 |
| Total current | 26,690 | 19,240 | 15,999 |
| Deferred | (715) | 264 | (368) |
| Total expense | $25,975 | $19,504 | $15,631 |

The following is a reconciliation of the expected income tax expense at U.S. Federal statutory rates to Centene's actual income tax expense for the years ended December 31:

| | 2004 | 2003 | 2002 |
|---|---|---|---|
| Expected federal income tax expense | $24,600 | $18,163 | $14,398 |
| State income taxes, net of federal income tax benefit | 1,975 | 1,602 | 1,520 |
| Tax exempt investment income | (1,030) | (916) | (411) |
| Other, net | 430 | 655 | 124 |
| Income tax expense | $25,975 | $19,504 | $15,631 |

Temporary differences that give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

| | 2004 | 2003 |
|---|---|---|
| Medical claims liabilities and other accruals | $ 8,696 | $3,992 |
| Allowance for doubtful accounts | 175 | 230 |
| Depreciation and amortization | 541 | 720 |
| Unearned revenue | 304 | 279 |
| Unrealized loss on investments | 353 | 156 |
| Total deferred tax assets | 10,069 | 5,377 |
| Identified intangible assets | 4,286 | 1,288 |
| Unrealized gain on investments | 41 | 472 |
| Prepaid expenses | 1,027 | 409 |
| Depreciation | 1,380 | 566 |
| Total deferred tax liabilities | 6,734 | 2,735 |
| Net deferred tax assets and liabilities | $ 3,335 | $2,642 |

## 9. Medical Claims Liabilities

The change in medical claims liabilities is summarized as follows:

| | 2004 | 2003 | 2002 |
|---|---|---|---|
| Balance, January 1 | $106,569 | $ 91,181 | $ 59,565 |
| Acquisitions | 24,909 | 335 | 16,230 |
| Incurred related to: | | | |
| Current year | 816,418 | 645,482 | 396,715 |
| Prior years | (15,942) | (19,290) | (17,247) |
| Total incurred | 800,476 | 626,192 | 379,468 |
| Paid related to: | | | |
| Current year | 681,780 | 544,309 | 324,210 |
| Prior years | 84,194 | 66,830 | 39,872 |
| Total paid | 765,974 | 611,139 | 364,082 |
| Balance, December 31 | $165,980 | $106,569 | $ 91,181 |

Changes in estimates of incurred claims for prior years were attributable to favorable development in all of our markets, including changes in medical utilization and cost trends. These changes in medical utilization and cost trends can be attributable to our medical management programs and changes in our member demographics.

The Company had reinsurance recoverables related to medical claims liabilities of $953 and $1,590 at December 31, 2004 and 2003, respectively, included in premiums and other receivables.

## 10. Revolving Line of Credit

In September 2004, the Company executed a five-year $100 million Revolving Credit Agreement with various financial institutions and LaSalle Bank National Association as administrative agent and arranger. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement is secured by the common stock and membership interests of the Company's subsidiaries. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, minimum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2009 or on an earlier date in the instance of a default as defined in the agreement. As of December 31, 2004, the Company was in compliance with all covenants. The outstanding borrowings at December 31, 2004 totaled $34,000, consisting of $30,000 bearing interest at 3.71% and $4,000 bearing interest at 5.25%.

## 11. Notes Payable and Long-term Debt

In August 2003, the Company borrowed $8,000 under a non-recourse mortgage loan arrangement to finance a portion of its purchase of its corporate headquarters' building. This mortgage was refinanced in November 2004 in conjunction with taking an additional mortgage in the amount of $5,500 related to property purchased to support the Company's expansion. The mortgages bear interest at the prevailing prime rate less .25%. At December 31, 2004 the mortgages bore interest at 5.00%. The mortgages are collateralized by the respective properties which had a net book value of $25,203 at December 31, 2004. The loans include a financial covenant requiring a minimum rolling twelve-month debt service coverage ratio. As of December 31, 2004, the Company was in compliance with this covenant. Maturities on the mortgages are as follows:

| | |
|---|---|
| 2005 | $ 486 |
| 2006 | 486 |
| 2007 | 486 |
| 2008 | 486 |
| 2009 | 486 |
| 2010 | 11,029 |
| Total | $13,459 |

In 2003, the Company issued a $581 promissory note payable as part of the acquisition of Cenpatico Behavioral Health. In 2004 this note was paid in full.

## 12. Stockholders' Equity

As approved by the Company's stockholders in May 2004, the Company has 10,000,000 authorized shares of preferred stock at $.001 par value and 100,000,000 authorized shares of common stock at $.001 par value. At December 31, 2004, there were no preferred shares outstanding.

## 13. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital requirements as required by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2004 and 2003, Centene's subsidiaries had aggregate statutory capital and surplus of $123,600 and $64,700, respectively, compared with the required minimum aggregate statutory capital and surplus of $65,100 and $30,900, respectively. The Company received dividends from its managed care subsidiaries of $0, $6,000 and $4,000 during the years ended December 31, 2004, 2003 and 2002, respectively.

## 14. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock awards and options to purchase common stock for key employees and other contributors to Centene. Both incentive options and nonqualified stock options can be awarded under the plans. Further, no option will be exercisable for longer than ten years after date of grant. The Plans have reserved 10,350,000 shares for option grants. Options granted generally vest over a five-year period beginning on the first anniversary of the date of grant and annually thereafter.

Option activity for the years ended December 31 is summarized below:

| | 2004 | | 2003 | | 2002 | |
|---|---|---|---|---|---|---|
| | Shares | Weighted Average Exercise Price | Shares | Weighted Average Exercise Price | Shares | Weighted Average Exercise Price |
| Options outstanding, beginning of year | 5,438,058 | $ 6.91 | 4,665,420 | $ 3.13 | 4,268,820 | $0.89 |
| Granted | 2,006,500 | 20.86 | 1,992,578 | 13.00 | 1,467,000 | 8.28 |
| Exercised | (1,003,098) | 3.76 | (877,786) | 1.13 | (832,200) | 0.55 |
| Canceled | (258,444) | 10.63 | (342,154) | 5.77 | (238,200) | 3.66 |
| Options outstanding, end of year | 6,183,016 | $11.78 | 5,438,058 | $ 6.91 | 4,665,420 | $3.13 |
| Weighted average remaining life | 7.8 years | | 7.6 years | | 7.4 years | |
| Weighted average fair value of options granted | $12.25 | | $7.63 | | $5.03 | |

The following table summarizes information about options outstanding as of December 31, 2004:

| | Options Outstanding | | | Options Exercisable | |
|---|---|---|---|---|---|
| Range of Exercise Prices | Options Outstanding | Weighted Average Remaining Contractual Life | Weighted Average Exercise Price | Options Exercisable | Weighted Average Exercise Price |
| $ 0.00 - $ 2.49 | 1,468,212 | 4.5 | $ 0.58 | 1,230,012 | $ 0.59 |
| $ 2.50 - $ 4.99 | 45,000 | 7.1 | 4.67 | 18,000 | 4.67 |
| $ 5.00 - $9.99 | 1,082,768 | 7.6 | 8.00 | 319,868 | 7.59 |
| $10.00 -$14.99 | 1,539,380 | 8.7 | 13.28 | 298,573 | 13.19 |
| $15.00 -$19.99 | 1,205,656 | 9.3 | 17.32 | 38,600 | 15.65 |
| $20.00 -$24.99 | 37,000 | 9.8 | 22.34 | — | — |
| $25.00 -$29.99 | 805,000 | 9.9 | 26.08 | — | — |
| | 6,183,016 | 7.8 | $11.78 | 1,905,053 | $ 4.08 |

The fair value of each option grant is estimated on the date of the grant using an option pricing model with the following assumptions: no dividend yield; expected volatility of 57%, 53% and 54%; risk-free interest rate of 3.7%, 3.1% and 3.6% and expected lives of 6.0, 6.0 and 7.4 for the years ended December 31, 2004, 2003 and 2002, respectively.

In 2004 the Company granted 1,000,000 restricted stock units with a grant date fair market value per share of $24.60. The restricted stock units will vest as follows: 600,000 in 2009 and 80,000 each in 2010 to 2014.

During 2002, Centene implemented an employee stock purchase plan. The Company has reserved 900,000 shares of common stock and issued 20,676 shares, 18,428 shares and 5,376 shares in 2004, 2003 and 2002, respectively, related to the employee stock purchase plan.

## 15. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who work at least 1,000 hours in a twelve consecutive month period and are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan were $822, $581 and $312 during the years ended December 31, 2004, 2003 and 2002, respectively.

## 16. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases. Rental expense was $5,482, $3,144 and $2,637 for the years ended December 31, 2004, 2003 and 2002, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows:

| | |
|---|---|
| 2005 | $ 6,766 |
| 2006 | 6,087 |
| 2007 | 5,157 |
| 2008 | 4,276 |
| 2009 | 3,622 |
| Thereafter | 7,613 |
| | $33,521 |

## 17. Contingencies

Aurora Health Care, Inc. (Aurora) provides medical professional services under a contract with the Company's Wisconsin health plan subsidiary. In May 2003, Aurora filed a lawsuit in the Milwaukee County Circuit Court claiming the Company had failed to adequately reimburse Aurora for services rendered during the period from 1998 to the present. In 2004 the Court dismissed the claim as filed, but allowed Aurora to replead and seek a declaratory ruling clarifying the contract with respect to reimbursement for ambulatory surgery services. Although the exact amount of the dispute has not been determined, Aurora claims it exceeds $8,000. The Company continues to dispute the claim and plans to defend against this matter.

The Company is routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters are uncertain, the Company does not expect the results of these matters to have a material effect on its financial position or results of operations.

## 18. Risks and Uncertainties

The Company's profitability depends in large part on accurately predicting and effectively managing medical services costs. The Company continually reviews its premium and benefit structure to reflect its underlying claims experience and revised actuarial data; however, several factors could adversely affect the medical services costs. Certain of these factors, which include changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters and malpractice litigation, are beyond any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control healthcare costs. Costs in excess of those anticipated could have a material adverse effect on the Company's results of operations.

Financial instruments that potentially subject the Company to concentrations of credit and interest rate risks consist primarily of cash and cash equivalents, investments in marketable securities and accounts receivable. The Company invests its excess cash in interest bearing deposits with major banks, commercial paper, repurchase agreements, government and agency securities and money market funds. Investments in marketable securities are managed within guidelines established by the Company's board of directors. The Company carries these investments at fair value.

Concentrations of credit risk with respect to accounts receivable are limited due to significant customers paying as services are rendered. Significant customers include the federal government and the states in which Centene operates. The Company has a risk of incurring loss if its allowance for doubtful accounts is not adequate.

As discussed in Note 3 to the consolidated financial statements, the Company has reinsurance agreements with insurance companies. The Company monitors the insurance companies' financial ratings to determine compliance with standards set by state law. The Company has a credit risk associated with these reinsurance agreements to the extent the reinsurers are unable to pay valid reinsurance claims of the Company.

## 19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per share for the years ended December 31:

| | 2004 | 2003 | 2002 |
|---|---|---|---|
| Net earnings | $ 44,312 | $ 33,270 | $ 25,621 |
| Shares used in computing per share amounts: | | | |
| Weighted average number of common shares outstanding | 40,820,909 | 35,704,426 | 31,432,080 |
| Dilutive effect of stock options and stock units (as determined by applying the treasury stock method) | 2,795,536 | 2,717,726 | 3,500,152 |
| Weighted average number of common shares and potential dilutive common shares outstanding | 43,616,445 | 38,422,152 | 34,932,232 |
| Basic net earnings per common share | $ 1.09 | $ 0.93 | $ 0.82 |
| Diluted net earnings per common share | $ 1.02 | $ 0.87 | $ 0.73 |

The calculation of diluted earnings per common share in 2003 excludes the impact of 1,317,820 shares related to stock options which are antidilutive.

## 20. Segment Information

With the acquisition of Cenpatico and the purchase of ScriptAssist assets on March 1, 2003, Centene began operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies including behavioral health, nurse triage and treatment compliance functions.

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision maker to evaluate all results of operations.

Segment information as of and for the year ended December 31, 2004, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Revenue from external customers | $ 993,304 | $ 7,636 | $ – | $1,000,940 |
| Revenue from internal customers | 60,329 | 21,923 | (82,252) | – |
| Total revenue | $1,053,633 | $29,559 | $(82,252) | $1,000,940 |
| Earnings before income taxes | $ 71,820 | $ (1,533) | $ – | $ 70,287 |
| Total assets | $ 519,799 | $ 8,135 | $ – | $ 527,934 |
| Depreciation expense | $ 4,682 | $ 467 | $ – | $ 5,149 |
| Capital expenditures | $ 24,726 | $ 283 | $ – | $ 25,009 |

Segment information as of and for the year ended December 31, 2003, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Revenue from external customers | $760,041 | $ 9,689 | $ – | $769,730 |
| Revenue from internal customers | 14,839 | 12,374 | (27,213) | – |
| Total revenue | $774,880 | $22,063 | $(27,213) | $769,730 |
| Earnings before income taxes | $ 49,764 | $ 2,129 | $ – | $ 51,893 |
| Total assets | $353,145 | $ 9,547 | $ – | $362,692 |
| Depreciation expense | $ 2,966 | $ 503 | $ – | $ 3,469 |
| Capital expenditures | $ 18,666 | $ 496 | $ – | $ 19,162 |

The Company evaluates performance and allocates resources based on earnings before income taxes. The accounting policies are the same as those described in the "Summary of Significant Accounting Policies" included in Note 3.

## 21. Comprehensive Earnings

Differences between net earnings and total comprehensive earnings resulted from changes in unrealized gains on investments available for sale, as follows:

| | *Year Ended December, 31,* | |
|---|---|---|
| | **2004** | **2003** |
| Net earnings | **$44,312** | $33,270 |
| Reclassification adjustment, net of tax | **(466)** | (529) |
| Unrealized gains on investments available for sale, net of tax | **(681)** | 182 |
| Total comprehensive income | **$43,165** | $32,923 |

## Management's Report on Consolidated Financial Statements

Management of Centene Corporation is responsible for the preparation of the consolidated financial statements and related financial information presented in the annual report and for ensuring its integrity and objectivity. These financial statements have been prepared in accordance with accounting principles generally accepted in the United States which require certain estimates and judgments based on management's assessment of current conditions and circumstances.

Management has established and maintains a system of internal financial controls that is designed to provide reasonable assurance that assets are safeguarded, transactions are properly recorded and the accounting records may be relied upon for the preparation of consolidated financial statements. We also maintain a system of disclosure controls and procedures to ensure transparent financial reporting and disclosure to keep our investors well informed. These systems are reviewed and improved based on changes in operations and business conditions.

In addition, we maintain an internal audit function which continually assesses the effectiveness of our internal control systems in accordance with a program approved by the Audit Committee.

The financial statements of the Company have been audited by an independent registered public accounting firm, who were selected by the Audit Committee. Management has made available to the independent registered public accounting firm all financial records and related data.

The Audit Committee, composed entirely of independent directors, meets regularly with management, the internal auditors and the independent registered public accounting firm to review accounting, internal control and financial reporting and disclosure matters. Both the internal auditors and the independent registered public accounting firm have full access to the Audit Committee and meet periodically with the Audit Committee without the presence of management.

## Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control – Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in Internal Control – Integrated Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2004. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2004 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Management has excluded the FirstGuard subsidiaries from its assessment of internal control over financial reporting as of December 31, 2004 because they were acquired by the Company in a purchase business combination effective December 1, 2004. The FirstGuard subsidiaries are wholly-owned subsidiaries whose total assets and total revenues represent 29% and 2%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2004.

## Other Information

The Company has included as Exhibits 31.1 and 31.2 to its Annual Report on Form 10-K for fiscal year 2004 filed with the Securities and Exchange Commission certificates of the Chairman and Chief Executive Officer, and Chief Financial Officer of the Company, certifying the quality of the Company's public disclosure. The Company submitted to the New York Stock Exchange a certificate of the Chairman and Chief Executive Officer of the Company certifying, for the prior fiscal year, that he is not aware of any violation by the Company of New York Stock Exchange corporate governance listing standards.

# Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Centene Corporation:

We have completed an integrated audit of Centene Corporation's 2004 consolidated financial statements and of its internal control over financial reporting as of December 31, 2004 and audits of its 2003 and 2002 consolidated financial statements in accordance with the standards of the Public Company Accounting Oversight Board (United States). Our opinions, based on our audits, are presented below.

## Consolidated financial statements

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of earnings, stockholders' equity and cash flows present fairly, in all material respects, the financial position of Centene Corporation and its subsidiaries at December 31, 2004 and 2003, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2004 in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

## Internal control over financial reporting

Also, in our opinion, management's assessment, included in the accompanying Management's Report on Internal Control Over Financial Reporting, that the Company maintained effective internal control over financial reporting as of December 31, 2004 based on criteria established in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), is fairly stated, in all material respects, based on those criteria. Furthermore, in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2004, based on criteria established in *Internal Control – Integrated Framework* issued by the COSO. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express opinions on management's assessment and on the effectiveness of the Company's internal control over financial reporting based on our audit. We conducted our audit of internal control over financial reporting in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. An audit of internal control over financial reporting includes obtaining an understanding of internal control over financial reporting, evaluating management's assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we consider necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As described in Management's Report on Internal Control Over Financial Reporting, management has excluded the FirstGuard subsidiaries from its assessment of internal control over financial reporting as of December 31, 2004 because they were acquired by the Company in a purchase business combination during 2004. We have also excluded the FirstGuard subsidiaries from our audit of internal control over financial reporting. The FirstGuard subsidiaries are wholly-owned subsidiaries whose total assets and total revenues represent 29% and 2%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2004.

PricewaterhouseCoopers LLP
St. Louis, Missouri
February 24, 2005

# Corporate Information

## Board of Directors

**Michael F. Neidorff**
*Chairman and CEO, Centene Corporation*

**Steve Bartlett**
*President and CEO*
*The Financial Services Roundtable*

**Samuel E. Bradt**
*President, Merganser Corporation*

**Robert K. Ditmore**
*Former President and COO*
*United Healthcare Corporation*

**John R. Roberts**
*Executive Director*
*Civic Progress of St. Louis*

**David L. Steward**
*Chairman of the Board*
*World Wide Technology, Inc.*

**Richard P. Wiederhold**
*President and CEO*
*Elizabeth A. Brinn Foundation*

## Senior Management

**Michael F. Neidorff**
*Chairman and CEO*

**Joseph P. Drozda, Jr., M.D.**
*Executive VP, Operations*

**James D. Donovan, Jr.**
*Sr. VP, New Products and New Markets*

**Marie J. Glancy**
*Sr. VP, Government Relations*

**Carol E. Goldman**
*Sr. VP and Chief Administrative Officer*

**Cary D. Hobbs**
*Sr. VP, Strategy and Business Implementation*

**Robert C. Packman, M.D.**
*VP and Chief Medical Officer*

**Daniel R. Paquin**
*Sr. VP, New Plan Implementation and Development*

**William N. Scheffel**
*Sr. VP and Controller*

**Brian G. Spanel**
*Sr. VP and Chief Information Officer*

**Lisa M. Wilson**
*Sr. VP, Investor Relations*

**Karey L. Witty**
*Sr. VP and Chief Financial Officer*

## Field Officers

**John (Jay) G. Belew**
*VP, Claims Operations, Montana*

**Christopher D. Bowers**
*President and CEO, Superior HealthPlan*

**Kathleen R. Crampton**
*VP, Business Development and Executive Chairman, MHS Wisconsin*

**Patricia J. Darnley**
*President and CEO*
*University Health Plans*

**Stephanie E. DeKemper**
*President, Centene Foundation for Quality Health Care*

**Samuel A. Donaldson, Ph.D.**
*President and CEO*
*Cenpatico Behavioral Health*

**Catherine S. Harvey**
*President and COO*
*Buckeye Community Health Plan*

**Rita Johnson-Mills**
*President and CEO, MHS Indiana*

**Kimberly D. Tuck**
*President and CEO, NurseWise*

**Bruce A. Weiss, M.D.**
*President and CEO, MHS Wisconsin*

**Joy D. Wheeler**
*President and CEO, FirstGuard*

## Officers

**Judy A. Bauer**
*VP, Care Management*

**David R. Craig**
*VP, Transportation Services*

**Richard L. Fredrickson**
*VP, SSI and Special Care Programs*

**Cynthia P. Jansky**
*VP, Human Resources*

**Michael G. Josias**
*VP, Organizational Development and Training*

**Angela S. Hanford**
*VP, Operational Services*

**Jesse N. Hunter**
*VP, Mergers and Acquisitions*

**Michael J. Lynch, M.D.**
*VP, Medical Affairs*

**Charles S. Mangene**
*VP, Health and Claims Information Systems*

**Robert J. Miromonti**
*VP, Ethics and Compliance*

**James E. Reh**
*VP, Facilities Management*

**Patrick J. Rooney**
*VP, Health Plan Finance*

**H. Robert Sanders**
*VP, Compensation and Benefits*

## Corporate and Investor Information

CORPORATE HEADQUARTERS
Centene Corporation
Centene Place
7711 Carondelet Avenue
St. Louis, Missouri 63105
314-725-4477
www.centene.com

## Form 10-K

The Company has filed an Annual Report on Form 10-K for the year ended December 31, 2004, with the Securities and Exchange Commission. Stockholders may obtain a copy of this report, without charge, by writing:

Investor Relations
Centene Corporation
Centene Place
7711 Carondelet Avenue
St. Louis, Missouri 63105

## Common Stock Information

Centene common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. From December 13, 2001, until October 15, 2003, Centene common stock was traded and quoted on the NASDAQ National Market under the symbol "CNTE."

All share and per share information presented below has been adjusted for a two-for-one stock split effected in the form of a 100% stock dividend paid December 17, 2004, to stockholders of record on November 24, 2004, and a three-for-two stock split effected in the form of a 50% stock dividend paid July 11, 2003, to stockholders of record on June 20, 2003.

| | | High | Low |
|---|---|---|---|
| 2003 | First Quarter | $11.62 | $ 7.45 |
| | Second Quarter | 13.22 | 9.39 |
| | Third Quarter | 15.80 | 12.28 |
| | Fourth Quarter | 17.85 | 13.49 |
| **2004** | **First Quarter** | **$16.48** | **$13.05** |
| | **Second Quarter** | **19.55** | **14.68** |
| | **Third Quarter** | **22.10** | **17.65** |
| | **Fourth Quarter** | **30.10** | **20.43** |

## Dividend Policy

The Company has not paid any dividends on its common stock, and expects that its earnings will continue to be retained for use in the operation and expansion of its business.

## Annual Meeting

The Annual Meeting of Shareholders will be held on Tuesday, April 26, 2005, at 10:00 a.m. at The Ritz-Carlton St. Louis, 100 Carondelet Plaza, St. Louis, MO 63105 in the Amphitheater, 314-863-6300.

## Transfer Agent

Mellon Investor Services
85 Challenger Road
Ridgefield Park, NJ 07660
888-213-0965
www.melloninvestor.com

CENTENE® Corporation

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