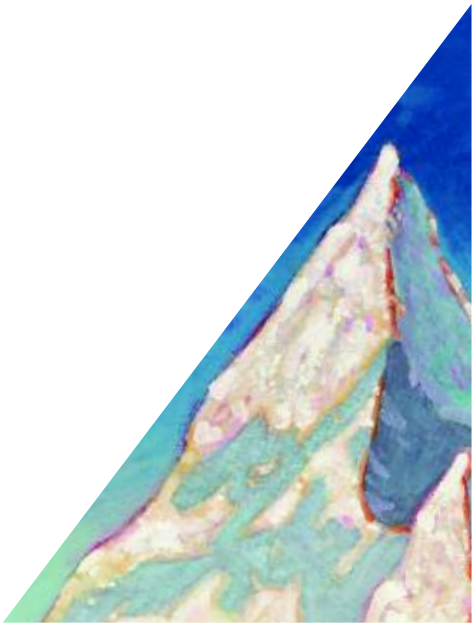
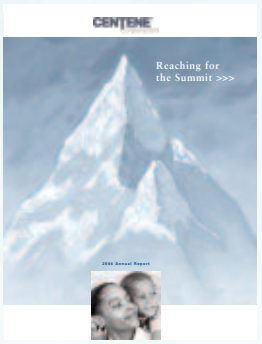
CENTENE® Corporation



Reaching for the Summit

2005 Annual Report

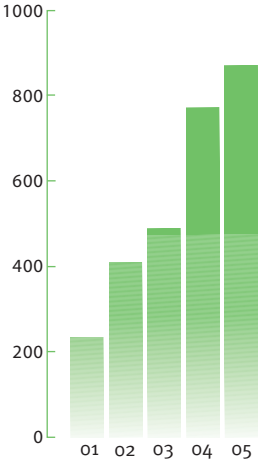
Centene Corporation is a leading *multi-line* health-care enterprise that provides programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). The Company operates health plans in Indiana, Kansas, Missouri, New Jersey, Ohio, Texas and Wisconsin. In addition, the Company contracts with other healthcare organizations to provide specialty services including behavioral health, disease management, nurse triage, pharmacy benefit management and treatment compliance. Information is available via the Internet at www.centene.com.



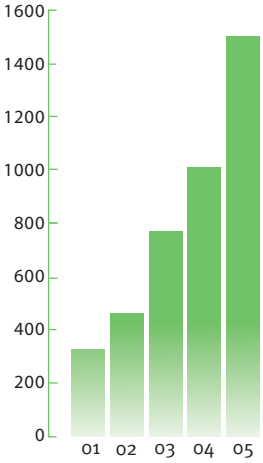
Financial Highlights

(in thousands)	2005	2004	*December 31,* 2003	2002	2001
Total revenues	**$1,505,864**	$1,000,940	$769,730	$461,487	$326,569
Earnings from operations	**79,191**	64,536	46,927	31,606	18,472
Net earnings	**55,632**	44,312	33,270	25,621	12,428
Total assets	**668,030**	527,934	362,692	210,327	131,366

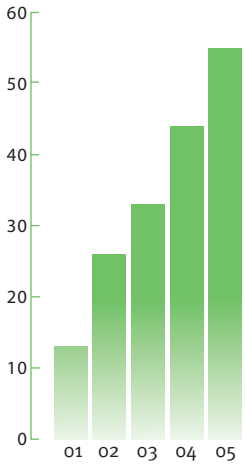
MEMBERSHIP
in thousands



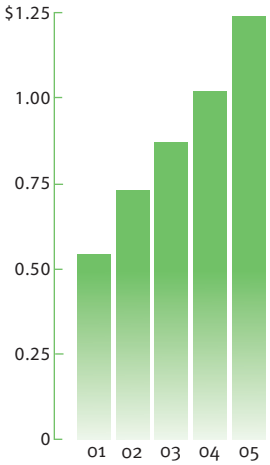
REVENUES
$ in millions



NET EARNINGS
$ in millions



DILUTED EARNINGS PER SHARE



Letter to Stockholders

A YEAR DISTINGUISHED BY PROGRESS

The year 2005 was distinguished by progress towards our goal of building a *multi-line* healthcare enterprise offering both core Medicaid and specialty services. We concluded the year with $1.5 billion in revenue and $55.6 million in net earnings, our strongest year ever, despite some market-specific challenges. We achieved our revenue and earnings per share objectives and continued to put in place measures for management succession planning. We also made investments in our information systems, producing greater operational efficiencies. All evidence indicates that we continue to execute on our strategy with discipline and intensity.

Membership at year end was 871,900, a 12.8% increase over 2004. Revenues, for the year ended December 31, 2005, increased 50.4% to $1.5 billion, and earnings per share increased to $1.24, an increase of 21.6%. Operating cash flow was $74.0 million, and our balance sheet is strong with $350.3 million in cash and investments. During 2005, we increased our credit facility to $200 million and have in place a universal shelf registration to fund future growth objectives.

During the year we expanded into new service territories and markets in Indiana, Kansas and Ohio, while strengthening our provider relationships and producing demonstrable cost savings to all of our states – our key customers. At Centene, we manage our core Medicaid business through a portfolio approach, which provides a diversification strategy and recognizes that at any given point in time there are different factors which can affect operations in our individual markets. In Indiana, we were pleased with the state's decision to roll out its remaining unconverted counties to mandatory managed care status and were successful in gaining membership and increasing our existing market share. In Wisconsin's Milwaukee county, the state commenced the transition of its SSI membership from voluntary to mandatory status, and we are eager to grow our SSI membership in our other states as well. We were also pleased with our membership growth in Kansas, where we are a dominant player and have expanded our already healthy relationship with the state.

Centene's discipline and steadfast adherence to basic core principles of contracting and reserving methodologies, as well as our commitment to act as local operators in our markets, continue to distinguish us in Medicaid managed care.

In our other markets, notably Ohio, Texas and Missouri, we faced some market-specific challenges. The state of Missouri elected to reduce the number of Medicaid recipients in an effort to balance its budget, while Ohio presented some challenges with respect to hospital contracting. In Texas, the state's assignment of a new enrollment broker and a new eligibility system affected our membership in 2005. However, we are well-poised to participate in the service area expansion awards that become effective in 2006.

As a result of a 2005 contract awarded by the Georgia Department of Community Health, this year we are prepared to enter three regions in the state. We will participate in the Atlanta, Central and Southwest regions, which collectively encompass 780,000 eligible recipients. Our management team is in place, and we have spent the last year negotiating contracts with hospitals and working to assemble our physician networks in order to provide the uncompromised, quality care to our members there for which our existing health plans are recognized.

We made substantial progress in 2005 in our specialty company segment, CenCorp Health Solutions™. With the July acquisition of AirLogix, a disease management company, and the year-end announcement of our purchase of US Script, a pharmacy benefit manager, we now have two additional capabilities from which to build our specialty platform expertise. AirLogix will benefit recipients who suffer from respiratory ailments such as chronic obstructive pulmonary disease and asthma. In the future, we will seek to cover other disease states in order to meet the needs of our recipients. US Script will enable us to contain and manage prescription drug costs – the most significant cost-driver in healthcare – as our health plan subsidiaries will contract with them at market rates and on an arms-length basis.

Our behavioral health programs in Arizona and Kansas are meeting the expectations of their respective market needs and provide a strong foundation to further demonstrate our skills and expertise in serving the needs of these recipients as we consider additional potential markets.

Michael F. Neidorff, Chairman and Chief Executive Officer

We continued to make progress in covering more SSI recipients and regard this population as an important opportunity for future revenue growth. Typically, SSI recipients are faced with chronic physical disabilities and often have secondary diagnoses, such as behavioral health conditions. Historically, because of the nature of their afflictions, SSI recipients have been treated in a traditional fee-for-service manner, which has higher costs. However, there are a number of ways in which we can meet the needs of this population while reducing the costs in managing their care. First, we take an integrated risk approach. For example, by offering generic drug substitution or formulary utilization, we can begin to effectively control or manage the very factors that influence these costs.

Other achievements during the year include the continued optimization of our information systems, which enable us to pay our doctors quickly and reduce our days in claims payable metric. Our Margin

Protection Program, which combines policy changes and rate increases, continues to be successful across our markets, and we have remained active in providing our states with opportunities to utilize this program to achieve cost savings. In December, we formally dedicated our new 50,000-square foot claims processing center in Great Falls, Montana. At the same time, we announced the establishment of an annual scholarship program to assist Montana students. We are proud to be part of the Great Falls community and look forward to fully occupying this facility over the next several years. Approximately 70 people have begun work at the site, and we anticipate eventually having more than 250 people employed there.

Recognition came from the business media. Centene was named to the *Forbes* Platinum 400, a list of America's Best Big Companies. In St. Louis, where we are headquartered, we were cited by *The St. Louis Business Journal* as one of the best places to work.

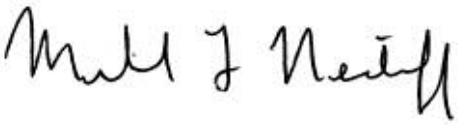
In April 2005, the Honorable Tommy Thompson, former Health and Human Services (HHS) Secretary and former Governor of Wisconsin, joined our board of directors for an initial two-year term. With nearly 40 years of his career devoted to public service, Secretary Thompson is recognized for his candor and as an advocate for the health and welfare of all Americans. His extensive experience and substantial contributions to the development of sound public policy will help Centene evolve to the appropriate paradigm under which healthcare is provided to low-income recipients.

We remain an industry leader. It is through Centene's discipline and steadfast adherence to basic core principles of contracting and reserving methodologies, our confidence in our systems and our commitment to acting as local operators in our markets, that continue to distinguish us in Medicaid managed care.

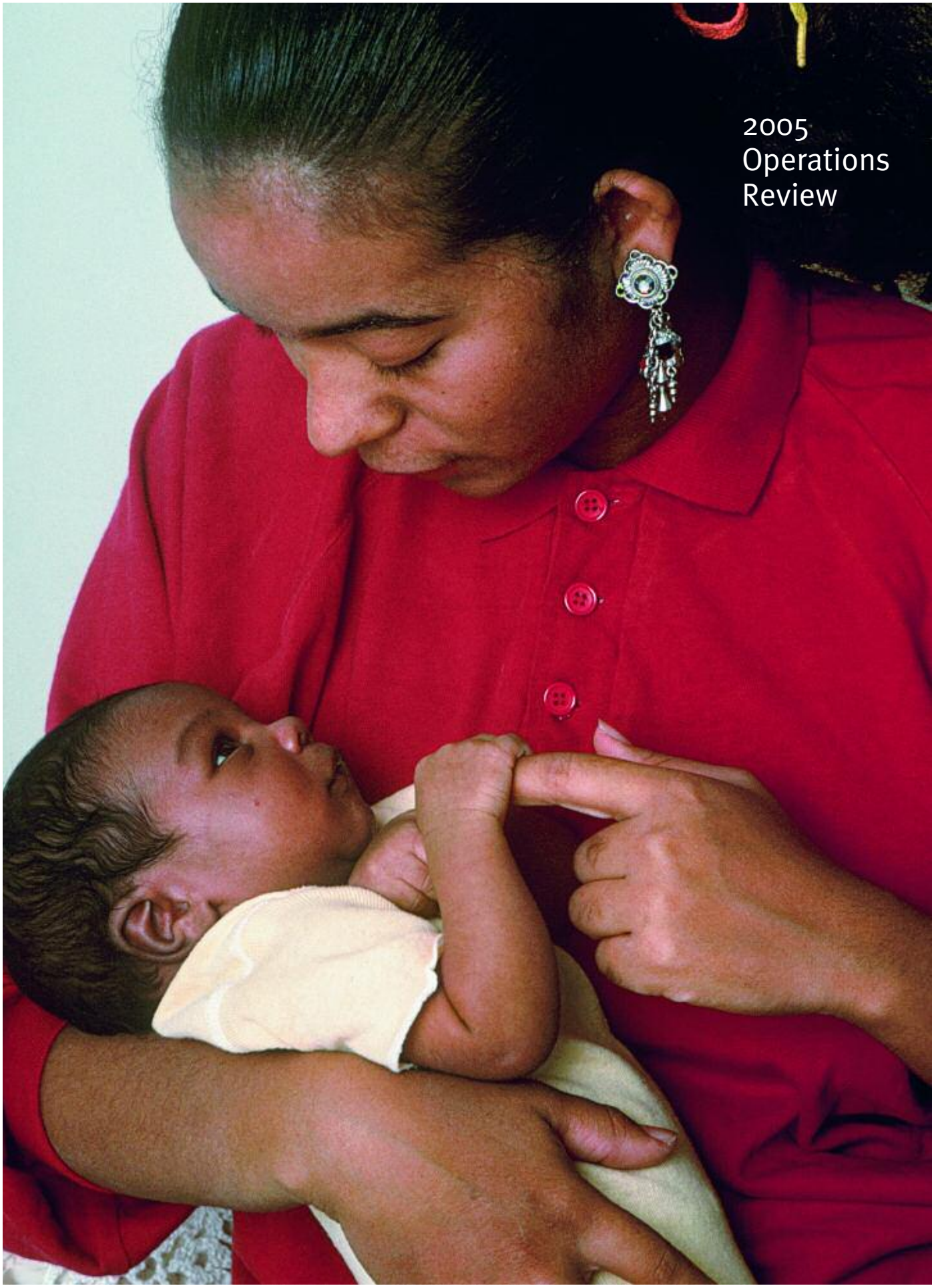
We remain committed without compromise in our belief that every American is entitled to receive quality healthcare with dignity. Centene has continued to build its business with this core value as our inspiration. States will continue to turn to managed care programs to fulfill their commitment to healthcare for Medicaid recipients, and we will in turn provide an appropriate solution.

Our ability to establish and maintain a leadership position in the industry and the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our customer-focused approach to working with state governments. It also comes from a culture flexible enough and comfortable enough with change. To that end, I would like to thank our employees for their continued commitment and dedication to the achievement of our growth objectives and ongoing success.

Sincerely,



Michael F. Neidorff
Chairman and Chief Executive Officer



2005 Operations Review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Reaching for Organizational Excellence

Centene has long taken pride in the depth of its management team and the individual expertise of each member of our senior staff. As Centene continues to evolve into a *multi-line* healthcare enterprise, it is paramount that we have the leadership in place to meet the challenges of a growing company.

It is also critical that each member of the Centene team understands his or her role in achieving our objectives. We recruit and retain the best, most highly skilled people in the Medicaid managed care industry in further support of building a *multi-line* healthcare enterprise. During the past year, we appointed several executives to newly created positions that deepen our reach and added senior staff to current management roles that strengthen our proficiencies.

To that end, Glendon Schuster has been appointed Vice President and Chief Information Officer of Centene Corporation. In this position he oversees Information Technology and Claims Operations, where he will continue to build on Centene's strengths in this core business function. Per Brodin was named Vice President and Chief Accounting Officer, a new position created to strengthen our reporting capabilities and further demonstrate our ongoing commitment to fiscal transparency. Mr. Brodin brings broad experience and skills in financial reporting, adding depth to an already strong financial team. Julia Ciorletti joined our Washington, D.C. office as Vice President, Government Relations. As such, she oversees federal and state legislative and regulatory policy and serves as Centene's liaison to Capitol Hill and the Administration. At CenCorp Health Solutions, our specialty services subsidiary, Leon Luttschwager was appointed Vice President, Operations and Business Processes, and will oversee the expansion and integration of specialty company businesses.

Succession planning is also underway. We have engaged Dr. Robert Lefton, President and CEO, Psychological Associates, a renowned executive management firm, to oversee and guide this process. Over the next 18 months, our senior staff will be rotated into different corporate roles and be evaluated for his or her expertise or other capability.

The skills and ongoing commitment of management and our dedicated staff are the fundamental elements that ensure that we remain focused on meeting our goals and objectives.

A Commitment to Transparency

Since our initial public offering in 2001, it has been our strict policy and practice to give our stockholders and other key constituents significant and increasing levels of transparency to help them understand how we approach our operations and the key metrics we use to conduct our business.

In September of 2005, we hosted a seminar in St. Louis entitled "Contracting & IBNR Accounting 101," in which the Company's methodologies around contracting and IBNR (Incurred But Not Reported) claims were presented and discussed.

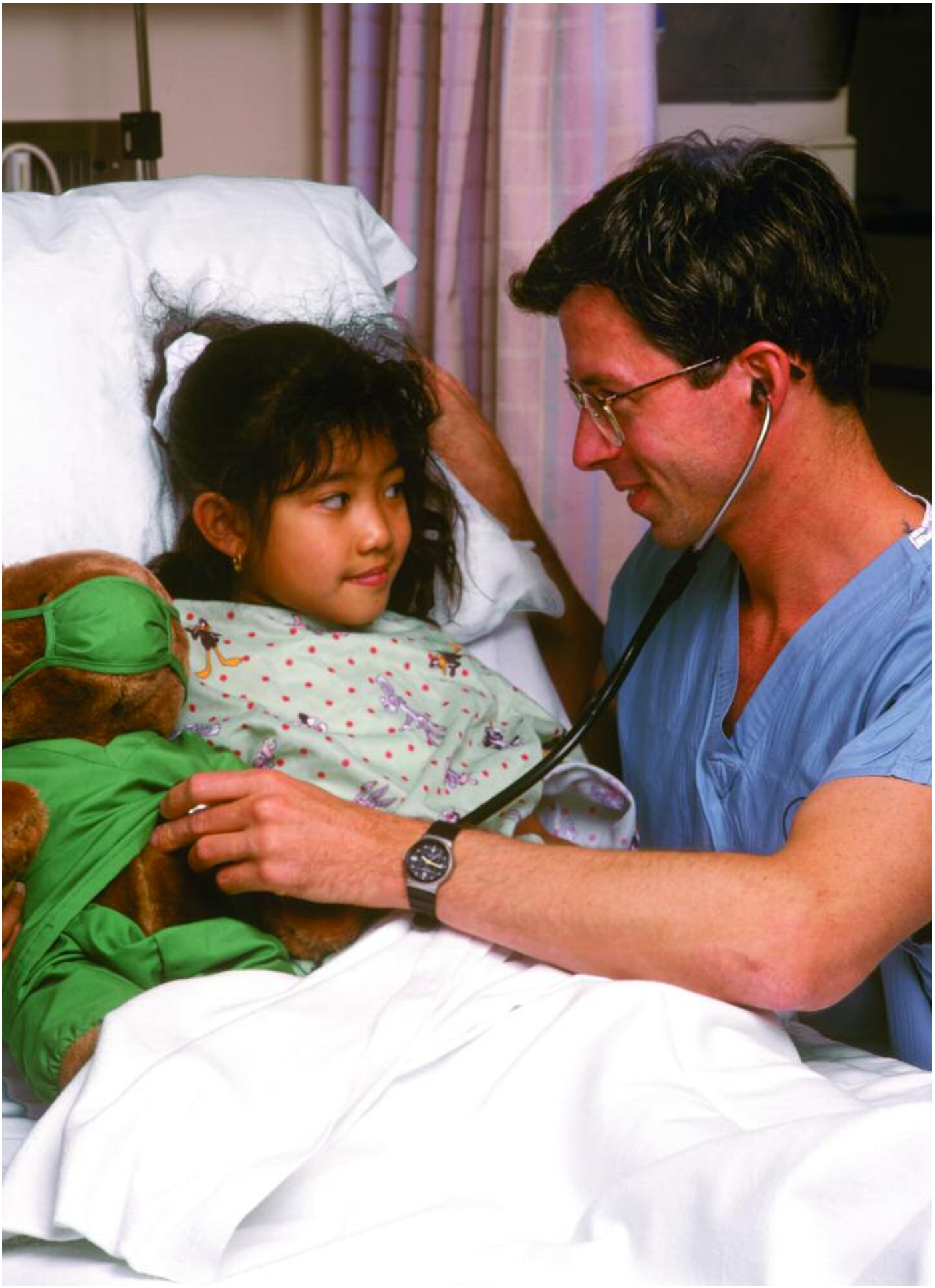
Furthermore, as part of the disciplined approach we have to our IBNR reserve methodologies, we employ two certified actuaries. In addition, our medical claims liabilities are evaluated by two independent external firms: Milliman USA, an actuarial firm, and KPMG LLP, as part of their 2005 financial statement audit. Specifically, we use an inventory method on the hospital inpatient side and a received completion and incurred PMPM method for all other fee-for-service or non-inpatient claims to estimate our reserves. These calculation metrics are timely, accurate and utilize conservative assumptions, which have resulted in positive prior period developments since 1999.

Centene believes that physicians should be rewarded for directing and delivering effective, accessible, comprehensive and coordinated healthcare to their patients while improving clinical outcomes. We collaborate with physicians as partners to help them establish a "medical home" for their patients and deliver quality care to our members at the same time. We endeavor to alleviate administrative burdens and moderate the cost of that care.

A significant percentage of our networked providers operates under Centene's proprietary Model One contract – a contracted system for primary care physicians that aligns incentives for maximizing the quality of care with outcomes for their patients' care. Importantly, it also encourages appropriate use of the healthcare system and the emergency department. This ultimately assists us in the management of unit costs and trends that support our underlying medical management efforts, aimed at ultimately improving the quality of care for our recipients.

In all of our contracting, we use a standardized approach, focusing on financially sound contracts which can be administered on our systems. These internal controls support our ability to manage our medical expenses and improve our ability to accurately estimate our health benefits ratio.

We view these rigorous standards as paramount to our success in the future, and it is part of our continued quest in *Reaching for the Summit*.



A Few Distinguishing Characteristics

Centene has worked hard to uphold its commitment as a distinguished leader in the Medicaid managed care and healthcare services industry. Our pledge to performance excellence and execution are the foundation of our long-term strategies and day-to-day operational decisions.

Prior to our initial public offering, Centene established rigorous compliance standards from which to transition to a publicly operated company. We operate in full accordance with Section 404 of the Sarbanes-Oxley Act. Our commitment to financial transparency is aimed at helping our investors to understand our business and stems from an inherent sense of integrity and uncompromised ethical standards. To that end, we provide detailed information for our member categories, Temporary Assistance for Needy Families (TANF), SCHIP and SSI, and transparency on claims statistics, health benefits ratio, premiums and G&A. Additionally, we file our Form 10-Q concurrent with our earnings release and our Form 10-K within a demanding timeframe and are one of the few public companies in the healthcare services sector to do so.

We have clearly defined our Medicaid-only and specialty company model, which serves as not only a key factor of our success, but a clear differentiator from our peers. We built the company for decentralized decision-making that is complemented by centralized systems support. This model allows us to deliver our services at the marketplace level – anything that touches a member, provider, contractor or regulator is done locally – and to meet community-specific and psycho-social challenges inherent to the Medicaid population. Our branding strategies further support this local approach, by operating through individual health plans – each with its own identity, specific for the market in which it operates. As for the specialty company segment, there exists an invisible wall between our health plan subsidiaries and each of our specialty companies, enabling the latter to contract with our own health plans and outside vendors and sell services to them at market rates.

Centene's success also rests firmly on the soundness and efficiency of our information systems platform. We provide centralized support at our St. Louis headquarters sharing functions such as finance, information systems, claims, and mergers and acquisitions, which provides an efficient and scalable model and allows us to know the status of our operations at all times. Furthermore, Centene's two claims locations operate on a common platform allowing for scalability and business resiliency.

Another distinguishing characteristic remains our disciplined approach to acquisitions, which is indispensable in creating and building stockholder value. Our criteria remain unchanged, recognizing that an acquisition materially changes the risk profile of our Company. We remain steadfast in our internal rate of return objective and are conservative when entering new markets, ensuring that the contracts and systems are in place to reach our goals.

Financial Review

Quarterly Selected Financial Information *(Unaudited)*

(In thousands, except share data and membership data)	*For the Quarter Ended,* March 31, 2005	June 30, 2005	September 30, 2005[1]	December 31, 2005[2]
Total revenues	**$332,376**	**$349,628**	**$400,642**	**$423,218**
Earnings from operations	**21,318**	**22,320**	**15,140**	**20,413**
Earnings before income taxes	**22,876**	**24,209**	**16,768**	**22,003**
Net earnings	**$ 14,411**	**$ 15,249**	**$ 12,106**	**$ 13,866**
Per share data:				
Basic earnings per common share	**$ 0.35**	**$ 0.36**	**$ 0.28**	**$ 0.32**
Diluted earnings per common share	**$ 0.32**	**$ 0.34**	**$ 0.27**	**$ 0.31**
Period end membership	**777,300**	**825,400**	**847,700**	**871,900**

[1] *Includes $4,500 pre-tax expense related to the settlement with Aurora Health Care, Inc. and $2,540 pre-tax expense related to our start up costs in Georgia.*
[2] *Includes $2,873 pre-tax expense related to our start up costs in Georgia.*

	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

Selected Financial Data

(In thousands, except share data)	Year Ended December 31, 2005	2004	2003	2002	2001
Statement of Earnings Data:					
Revenues:					
Premium	**$1,491,899**	$ 991,673	$759,763	$461,030	$326,184
Service	**13,965**	9,267	9,967	457	385
Total revenues	**1,505,864**	1,000,940	769,730	461,487	326,569
Expenses:					
Medical costs	**1,226,909**	800,476	626,192	379,468	270,151
Cost of services	**5,851**	8,065	8,323	341	329
General and administrative expenses	**193,913**	127,863	88,288	50,072	37,617
Total operating expenses	**1,426,673**	936,404	722,803	429,881	308,097
Earnings from operations	**79,191**	64,536	46,927	31,606	18,472
Other income (expense):					
Investment and other income	**10,655**	6,431	5,160	9,575	3,916
Interest expense	**(3,990)**	(680)	(194)	(45)	(362)
Earnings before income taxes	**85,856**	70,287	51,893	41,136	22,026
Income tax expense	**30,224**	25,975	19,504	15,631	9,131
Minority interest	**–**	–	881	116	–
Net earnings	**55,632**	44,312	33,270	25,621	12,895
Accretion of redeemable preferred stock	**–**	–	–	–	(467)
Net earnings attributable to common stockholders	**$ 55,632**	$ 44,312	$ 33,270	$ 25,621	$ 12,428
Net earnings per common share:					
Basic	**$ 1.31**	$ 1.09	$ 0.93	$ 0.82	$ 2.99
Diluted	**$ 1.24**	$ 1.02	$ 0.87	$ 0.73	$ 0.54
Weighted average number of common shares outstanding:					
Basic	**42,312,522**	40,820,909	35,704,426	31,432,080	4,156,198
Diluted	**45,027,633**	43,616,445	38,422,152	34,932,232	24,058,492

(In thousands)	December 31, 2005	2004	2003	2002	2001
Balance Sheet Data:					
Cash and cash equivalents	**$ 147,358**	$ 84,105	$ 64,346	$ 59,656	$ 88,867
Investments	**180,361**	211,070	199,971	89,237	22,288
Total assets	**668,030**	527,934	362,692	210,327	131,366
Medical claims liabilities	**170,514**	165,980	106,569	91,181	59,565
Debt	**93,147**	47,459	8,195	–	–
Total stockholders' equity	**352,048**	271,312	220,115	102,183	64,089

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 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 healthcare enterprise operating in two segments. Our Medicaid Managed Care segment 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). Our Specialty Services segment operates through contracts with our health plans, as well as other healthcare organizations, state programs and other commercial organizations. These specialty services include behavioral health, disease management, nurse triage and treatment compliance. Effective January 2006, our specialty services also include pharmacy benefits management through our acquisition of US Script, Inc.

Our 2005 financial highlights include:

- Year-end Medicaid Managed Care membership of 871,900.
- Revenues of $1.5 billion, a 50% increase over 2004.
- Medicaid and SCHIP health benefits ratio (HBR) of 81.7%, SSI HBR of 97.5%, Specialty Services HBR of 88.1%.
- Medicaid Managed Care general and administrative (G&A) expense ratio of 10.5% and Specialty Services G&A ratio of 35.4%.
- Operating earnings of $79.2 million, a 23% increase over 2004.
- Diluted earning per share of $1.24, a 22% increase over 2004.
- Operating cash flows of $74 million.

Over the last 2 years we have experienced strong growth in our Medicaid Managed Care segment including membership growth of 78%. Highlights of our growth include the following acquisitions or new contracts:

- During the third quarter of 2005 we were awarded Medicaid contracts in Georgia by the Georgia Department of Community Health. Our subsidiary, Peach State Health Plan, Inc., will manage care for a portion of the Medicaid and SCHIP recipients in the Atlanta, Central and Southwest regions. Membership operations are scheduled to commence in 2006.
- Effective May 1, 2005, we acquired certain Medicaid-related assets of SummaCare, Inc. for approximately $30.4 million. The results of operations of this entity are included in our consolidated financial statements beginning May 1, 2005.
- Effective December 1, 2004, we acquired FirstGuard, Inc. and FirstGuard Health Plan, Inc. (FirstGuard), for a purchase price of $96.0 million. The results of operations of this entity are included in our consolidated financial statements beginning December 1, 2004.
- Effective September 1, 2004, we commenced operations under our Exclusive Provider Organization (EPO) contract in Texas providing managed care for SCHIP recipients in rural Texas counties.
- Effective January 1, 2004, we commenced operations in Ohio through the acquisition of the Medicaid-related assets of Family Health Plan, Inc. (FHP) for a purchase price of $6.9 million. The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2004.

We have also experienced growth in our Specialty Services segment highlighted by the following acquisitions or new contracts:

- In January 2006, we acquired US Script, Inc., a privately held pharmacy benefits manager (PBM) for $40 million. The results of operations of this entity will be included in our consolidated financial statements beginning January 1, 2006.
- Effective July 22, 2005, we acquired AirLogix, Inc., a disease management provider, for a purchase price of approximately $36.2 million. The results of operations of this entity are included in our consolidated financial statements since July 22, 2005.
- Effective July 1, 2005, we began performing under our contract with the State of Arizona to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Arizona.
- Effective January 1, 2005, we began performing under our contract with the State of Kansas to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Kansas.

RESULTS OF OPERATIONS AND KEY METRICS

Summarized comparative financial data for 2005, 2004 and 2003 are as follows ($ in millions):

	2005	2004	2003	% Change 2004-2005	% Change 2003-2004
Premium revenue	**$1,491.9**	$ 991.7	$759.7	50.4%	30.5%
Service revenue	**14.0**	9.2	10.0	50.7%	(7.0)%
Total revenues	**1,505.9**	1,000.9	769.7	50.4%	30.0%
Medical costs	**1,226.9**	800.5	626.2	53.3%	27.8%
Cost of services	**5.9**	8.1	8.3	(27.5)%	(3.1)%
General and administrative expenses	**193.9**	127.8	88.3	51.7%	44.8%
Earnings from operations	**79.2**	64.5	46.9	22.7%	37.5%
Investment and other income, net	**6.6**	5.8	5.0	15.9%	15.8%
Earnings before income taxes	**85.8**	70.3	51.9	22.2%	35.4%
Income tax expense	**30.2**	26.0	19.5	16.4%	33.2%
Minority interest	**–**	–	0.9	–%	–%
Net earnings	**$ 55.6**	$ 44.3	$ 33.3	25.5%	33.2%
Diluted earnings per common share	**$ 1.24**	$ 1.02	$ 0.87	21.6%	17.2%

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 health plans. 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. Some contracts allow for additional premium related to certain supplemental services provided such as maternity deliveries. 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.

We generate revenues in our Specialty Services segment under contracts with states and local government entities, our health plans and third-party customers. Revenues are recognized when the services are provided or as ratably earned over the covered period of services. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance. Such amounts are recorded as unearned revenue.

Premium and service revenues collected in advance are recorded as unearned revenue. Premium and service revenues 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 payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

We have increased our total revenue each year primarily through 1) membership growth in the Medicaid Managed Care segment, 2) premium rate increases, and 3) growth in our Specialty Services segment.

1. Membership growth

From December 31, 2003 to December 31, 2005, we increased our membership by 78.1%. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	December 31,		
	2005	2004	2003
Indiana	**193,300**	150,600	119,400
Kansas	**113,300**	94,200	–
Missouri	**36,000**	41,200	–
New Jersey	**56,500**	52,800	54,000
Ohio	**58,700**	23,800	–
Texas	**242,000**	244,300	158,400
Wisconsin	**172,100**	165,800	157,800
Total	**871,900**	772,700	489,600

The following table sets forth our membership by line of business in our Medicaid Managed Care segment:

	December 31,		
	2005	2004	2003
Medicaid	**681,100**	580,200	411,800
SCHIP	**175,900**	182,100	68,400
SSI	**14,900**	10,400	9,400
Total	**871,900**	772,700	489,600

In 2005, we increased our membership in Ohio through our acquisition of the Medicaid-related assets of SummaCare, Inc. Our membership increased in Indiana, New Jersey and Wisconsin from additions to our provider networks, expansion into SSI in Wisconsin, increases in counties served and growth in the overall number of Medicaid beneficiaries. In Kansas, we

increased our membership by eliminating a ceiling on our membership total with the State. Our membership decreased in Missouri and Texas because of more stringent eligibility requirements for the Medicaid and SCHIP programs.

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 FHP. 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.

2. Premium rate increases

In 2005, we received premium rate increases ranging from 0.6% to 8.7%, or 3.2% on a composite basis across our markets. In 2004, we received premium rate increases ranging from 2.3% to 5.3%, or 4.4% on a composite basis across our markets.

3. Specialty Services segment growth

In 2005, we began performing under our behavioral health contracts with the States of Arizona and Kansas. At December 31, 2005, our behavioral health company, Cenpatico, provided behavioral health services to 94,700 members in Arizona, 38,800 members in Kansas and 702,100 members through contracts with our health plans compared to 584,500 members through contracts with our health plans at December 31, 2004. Additionally, in July 2005 we began offering disease management services through our acquisition of AirLogix.

Operating Expenses

Medical Costs

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. 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 HBR 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 HBR for our external membership by member category:

	Year Ended December 31,		
	2005	2004	2003
Medicaid and SCHIP	**81.7%**	80.4%	81.7%
SSI	**97.5**	93.8	102.5
Specialty Services	**88.1**	–	–

Our Medicaid and SCHIP HBR increased in 2005 due to our settlement of a lawsuit with Aurora Health Care, Inc., which increased our ratio by 0.3%; and expansion into new markets previously unmanaged by us; which increased our ratio by 1.2%. For example, we experienced higher cost trends in Indiana where we added membership in 2005 as the state expanded their Medicaid managed care program to include all Medicaid and SCHIP enrollees. Our Specialty Services ratio includes the behavioral health contracts in Arizona and Kansas and reflects the State of Arizona's minimum HBR requirements.

Our Medicaid and SCHIP HBR decreased in 2004 from 2003 due primarily to initiatives to reduce inappropriate emergency room usage and to establish preferred drug lists.

Cost of Services

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.

General and Administrative Expenses

Our general and administrative (G&A) 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. Our major centralized functions are finance, information systems and claims processing. Premium taxes are classified as G&A expenses. G&A expenses increased in 2005 primarily due to expenses for additional facilities and staff to support our growth, especially in Arizona, Georgia, Kansas and Missouri.

Our G&A 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 earn those revenues. The following table sets forth the general and administrative expense ratios by business segment and in total:

	Year Ended December 31,		
	2005	2004	2003
Medicaid Managed Care	**10.5%**	10.7%	10.3%
Specialty Services	**35.4**	52.3	38.2

The decrease in the Medicaid Managed Care G&A expense ratio in 2005 reflects the overall leveraging of our expenses over higher revenues and lower compensation costs related to our performance bonus plans. These factors were partially offset by implementation costs in Georgia of $6.2 million, higher spending on information systems process improvements and increased charitable contributions. Premium taxes totaled $9.8 million in 2005, increasing the ratio by 0.5%.

The increase in the Medicaid Managed Care G&A expense 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 million in 2003 and had the effect of increasing our G&A expense 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 G&A ratio varies depending on the nature of the services provided and will have a higher general and administrative expense ratio than the Medicaid Managed Care segment. The 2005 results reflect the operations of our behavioral health company in Arizona, including $1.5 million in implementation costs, and $0.2 million in Georgia implementation costs. 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 transitioned 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 income from our cash and investments and interest expense on our debt. Investment and other income increased $4.2 million in 2005 as a result of higher average investment balances and an increase in market interest rates. Interest expense increased $3.3 million from increased borrowings under our credit facility and mortgages.

Income Tax Expense

Our effective tax rate in 2005 was 35.2%, compared to 37.0% in 2004. The decrease was primarily due to a lower state income tax expense resulting from the resolution of state income tax examinations and the recognition of deferred tax benefits related to a change in law during the third quarter of 2005. This change was recorded in our operating results in the period known.

Earnings Per Share and Shares Outstanding

Our earnings per share calculations in 2005 reflect higher basic weighted average shares outstanding resulting from the shares issued upon exercise of stock awards and the shares issued for the acquisition of assets from SummaCare, Inc. Our earnings per share calculations in 2004 reflect an increase in the weighted average shares primarily resulting from 6,900,000 common shares sold in August 2003.

LIQUIDITY AND CAPITAL RESOURCES

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our operating activities provided cash of $74.0 million in 2005, $99.4 million in 2004 and $56.0 million in 2003. Cash flow from operations in 2005 reflects an increase in premium and related receivables and a $4.5 million increase in medical claims liabilities. The increase in receivables resulted primarily from the timing of delivery receivable collections. The increase in medical claims liabilities, lower than in prior years, reflects the $9.5 million payment made to Aurora Health Care, Inc. to settle a lawsuit, information systems improvements to reduce our claims processing cycle time and the effect of our behavioral health contract in Arizona. During 2004, the increase in operating cash flow was due primarily to continued profitability, increases in membership and increases in medical claims liabilities.

Our investing activities used cash of $56.4 million in 2005, $122.5 million in 2004 and $140.7 million in 2003. During 2005, our investing activities primarily consisted of the acquisitions of AirLogix and certain Medicaid-related assets of SummaCare, Inc. Approximately $34.1 million was paid, net of cash acquired, for AirLogix. Of the total purchase price of approximately $30.4 million paid to SummaCare, $21.4 million was paid in cash and the remaining $9.0 million was paid through the issuance of our common stock. During 2004, our investing activities primarily consisted of the acquisition of FirstGuard. In 2003, the largest component of investing activities related to increases in our investment portfolio as a result of our stock offering. 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, 2005, our investment portfolio consisted primarily of fixed-income securities with an average duration of 1.6 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.

We spent $26.9 million, $14.7 million and $6.6 million in 2005, 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. We anticipate spending $43 million on additional capital expenditures in 2006 primarily related

to market expansions and system upgrades, and approximately $20 million for the acquisition of additional property related to our redevelopment agreement discussed below.

Effective December 30, 2005, we executed an agreement with the City of Clayton, Missouri, a suburb of St. Louis, for the redevelopment of certain properties surrounding our corporate offices. Our primary purpose for the agreement is to accommodate office expansion needs for future company growth. The total scope of the project includes building two new office towers and street-level retail space. We plan to occupy a portion of those towers. The total expected cost of the project is approximately $190 million. It is not our intent to serve as developer of the project; we expect a commercial real estate developer to fund the majority of the project cost.

During 2005, we acquired $5.0 million of property under capital leases. This property consists primarily of the land and building related to our new claims processing facility in Montana. 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 is being used for the 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. The mortgage agreements bear interest at the prevailing prime rate less .75%. At December 31, 2005, our mortgages bore interest at 6.5%.

Our financing activities provided cash of $45.7 million in 2005, $42.8 million in 2004 and $89.4 million in 2003. During 2005 and 2004, our financing activities primarily related to proceeds from borrowings under our credit facility. These borrowings were used primarily for our investing activities in conjunction with the acquisition of new business. 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.

At December 31, 2005, we had working capital, defined as current assets less current liabilities, of $58.0 million as compared to $22.1 million at December 31, 2004. 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 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 short-term capital requirements as needed.

Cash, cash equivalents and short-term investments were $204.1 million at December 31, 2005 and $178.4 million at December 31, 2004. Long-term investments were $146.2 million at December 31, 2005 and $139.0 million at December 31, 2004, including restricted deposits of $22.6 million and $22.2 million, respectively. At December 31, 2005, cash and investments held by our unregulated entities totaled $27.7 million while cash and investments held by our regulated entities totaled $322.6 million.

On September 9, 2005, we executed an amendment to our Revolving Credit Agreement dated September 14, 2004, with several lending institutions, for which LaSalle Bank National Association serves as administrative agent and co-lead arranger. The amendment increased the total amount available under the credit agreement to $200 million from $100 million, including a sub-facility for letters of credit in an aggregate amount up to $50 million. In addition, the lending institutions released our prior grant of a security interest in the outstanding common stock and membership interests of each of our subsidiaries. The credit agreement is now an unsecured facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. Under our current capital structure, borrowings under the agreement bear interest at LIBOR plus 1.25%. This rate may change under differing capital structures over the life of the agreement. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire on September 9, 2010 or on an earlier date in the instance of a default as defined in the agreement. As of February 23, 2006, we had $109.0 million in borrowings outstanding under the agreement and $15.0 million in letters of credit outstanding, leaving an availability of $76.0 million. As of December 31, 2005, we were in compliance with all covenants.

We have filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission, or the SEC, covering the issuance of up to $300 million of securities including common stock and debt securities. No securities have been issued under the shelf registration. We may publicly offer securities from time-to-time at prices and terms to be determined at the time of the offering.

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 and capital expenditures for at least 12 months from the initial date of mailing of this report to our stockholders.

Our principal contractual obligations at December 31, 2005 consisted of medical claims liabilities, debt, operating leases and purchase obligations. Our debt consists of borrowings from our credit facility, mortgages and capital leases. The purchase obligations consist primarily of software purchase and maintenance contracts in addition to agreements pertaining to the 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	$170,514	$170,514	$ –	$ –	$ –
Debt	93,147	699	1,376	86,822	4,250
Operating leases	46,515	9,210	16,120	11,444	9,741
Purchase obligations	15,509	9,626	5,783	100	–
Total	$325,685	$190,049	$23,279	$98,366	$13,991

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

As managed care organizations, certain of our 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, 2005, our regulated subsidiaries had aggregate statutory capital and surplus of $183.5 million, compared with the required minimum aggregate statutory capital and surplus requirements of $87.7 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, 2005, our Georgia, Indiana, New Jersey, Ohio, Texas and Wisconsin health plans were in compliance with risk-based capital requirements enacted in these states. If adopted by Kansas or Missouri, risk-based capital requirements may increase the minimum capital required for these subsidiaries. We continue to monitor the requirements in Kansas and Missouri 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 FASB issued Statement of Financial Accounting Standards No. 123 (revised 2004), "Share Based Payment," (SFAS 123R). SFAS 123R focuses primarily on accounting for transactions in which an entity obtains employee services in share-based payment transactions. SFAS 123R 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. We will adopt SFAS 123R on January 1, 2006 using the modified-prospective method, and expect the 2006 effect to decrease diluted earnings per share by approximately $0.15.

CRITICAL ACCOUNTING POLICIES

Our significant accounting policies are more fully described in Note 2 to our 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 (inventory), 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, 2005 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)%	$ 26,500	(3)%	$(7,000)
(2)	17,500	(2)	(4,700)
(1)	8,600	(1)	(2,400)
1	(8,500)	1	2,400
2	(16,800)	2	4,800
3	(24,900)	3	7,200

[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 our 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 $1.1 million for the year ended December 31, 2005. 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,		
	2005	2004	2003
Balance, January 1	**$ 165,980**	$106,569	$ 91,181
Acquisitions	**–**	24,909	335
Incurred related to:			
Current year	**1,244,600**	816,418	645,482
Prior years	**(17,691)**	(15,942)	(19,290)
Total incurred	**1,226,909**	800,476	626,192
Paid related to:			
Current year	**1,075,204**	681,780	544,309
Prior years	**147,171**	84,194	66,830
Total paid	**1,222,375**	765,974	611,139
Balance, December 31	**$ 170,514**	$165,980	$106,569
Claims inventory, December 31	**255,000**	150,000	131,000
Days in claims payable[a]	**45.4**	66.5	59.0

[a] *Days in claims payable 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. Days in claims payable decreased in 2005 due to the settlement of a lawsuit with Aurora Health Care, Inc., information systems improvements to reduce our claims processing cycle time and the effect of our behavioral health contract in Arizona. Acquisitions in the last quarter of 2004 contributed to an increase in our 2004 days in claims payable calculation.*

Acquisitions in 2004 include reserves acquired in connection with our acquisition of FirstGuard. Acquisitions in 2003 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 healthcare provider. As a result, these liabilities generally are described as having a "short-tail," which causes less than 5% 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, 2005 will be known by the end of 2006.

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, 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 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 2003 that have resulted in our recording of intangible assets. These intangible assets primarily consist of purchased contract rights, provider contracts, non-compete agreements and goodwill. At December 31, 2005 we have $157.3 million of goodwill and $17.4 million of other intangible assets. Purchased contract rights are amortized using the straight-line method over periods ranging from 5 to 15 years. Provider contracts are amortized using the straight-line method over periods ranging from 5 to 10 years. Non-compete agreements are amortized using the straight-line method over 5 years, the period of the agreement.

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 or goodwill may be permanently impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or 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 every year during the fourth quarter 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, 2005.

FORWARD-LOOKING STATEMENTS

This 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 "Management's Discussion and Analysis of Financial Condition and Results of Operations." 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, including the factors set forth in "Factors That May Affect Future Results and the Trading Price of Our Common Stock." 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 filing, 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 that would have required 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 October 2005, CMS announced an interim rule under which a CMS contractor will randomly select states for review once every three years to estimate each state's rate of erroneous payments, the federal share of which the states will be required to return to CMS.

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. The Bush administration has also proposed to reduce total federal funding for the Medicaid program by $10 billion over the next five years and both the House of Representatives and the Senate have approved budget bills containing Medicaid reductions. Some states, including Texas, have been authorized to implement special measures to accommodate the arrival of large numbers of beneficiaries from Gulf Coast areas evacuated as a result of hurri-

canes Katrina and Rita, but it is unknown whether these measures will be sufficient to cover the additional Medicaid costs incurred by these states. The newly effective Medicare prescription drug benefit is interrupting prescription drug coverage for many Medicaid beneficiaries, prompting several states to pay for prescription drugs on an emergency basis without any assurance of receiving reimbursement from Medicaid.

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. In recent 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, 2006 and August 31, 2008. 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 one or 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 the Financial Interests of 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 the financial interests of 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 premium 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 such 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.

In recent years, CMS has reduced the rates at which states are permitted to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services, with the upper payment limit decreasing to 100% of Medicare payments for comparable services. Any further reductions in this limit could decrease 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 May Incur Significant Increased Costs as a Result of Compliance With New Government Regulations and Our Management Will Be Required to Devote Time to Compliance.

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 this regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with recent security regulations. In order to comply with new regulatory requirements, we were required to employ additional or different programs and systems. Further, compliance with new regulations could require additional 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, or the NYSE, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will continue to devote 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 the effectiveness of 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 requires 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, 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 and Benefits 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, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. 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, benefits provided or our contract arrangements may seriously harm our operations and financial results.

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

States may administer Medicaid managed care programs pursuant to demonstration programs or required waivers of federal Medicaid standards. Waivers and demonstration programs are generally 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 such a waiver or demonstration program or the Federal government denies a state's application for renewal, membership in our health plan in the state could decrease and our business could suffer.

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. 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 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. The Administration has also proposed to reduce total federal funding for the Medicaid program by $10 billion over the next five years, and both the House and the Senate have approved budget bills containing Medicaid reductions. Some states, including Texas, have been authorized to implement special measures to accommodate the arrival of large numbers of beneficiaries from Gulf Coast areas evacuated as a result of hurricanes Katrina and Rita, but it is unknown whether these measures will be sufficient to cover the additional Medicaid costs incurred by these states. 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, revised cost-sharing requirements for some beneficiaries and requires 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. The new Medicare prescription drug benefit is interrupting the distribution of prescription drugs to many beneficiaries simultaneously enrolled in both Medicaid and Medicare, prompting several states to pay for prescription drugs on an unbudgeted, emergency basis without any assurance of receiving reimbursement from the federal Medicaid program. These expenses may cause some states to divert funds originally intended for other Medicaid services.

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

Ineffectiveness of State-operated Systems and Subcontractors Could Adversely Affect Our Business

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible clients into the health plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible clients into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

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

Our medical expenses include estimates of incurred but not reported (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.

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 revenue, 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. 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.

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.

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;
- 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 effectively execute our acquisition strategy, 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 2005, for example, we acquired Airlogix, Inc., a disease management 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 Arizona, 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 Relationships With Our Provider Networks, Our Profitability May 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 Statement of Financial Accounting Standards No. 123 (revised 2004) "Share Based Payment," (SFAS 123R) which would require all companies to measure compensation cost for all share-based payments, including employee stock options, at fair value. In April 2005 the SEC delayed the implementation until the first annual period beginning after June 15, 2005. We are required to and will adopt SFAS 123R on January 1, 2006. The effect of expensing stock options in accordance with the original SFAS 123 is presented in Note 2 of our Notes to Consolidated Financial Statements included elsewhere in this Form 10-K.

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, the majority of 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 and regulatory requirements. 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, 2005, we had short-term investments of $56.7 million and long-term investments of $146.2 million, including restricted deposits of $22.6 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. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. 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, 2005, the fair value of our fixed income investments would decrease by approximately $3.1 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 our margin protection program and 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 in recent years. 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,* 2005	2004
Assets		
Current assets:		
Cash and cash equivalents	**$147,358**	$ 84,105
Premium and related receivables, net of allowances of $343 and $462, respectively	**44,108**	31,475
Short-term investments, at fair value (amortized cost $56,863 and $94,442, respectively)	**56,700**	94,283
Other current assets	**24,439**	14,429
Total current assets	**272,605**	224,292
Long-term investments, at fair value (amortized cost $126,039 and $117,177, respectively)	**123,661**	116,787
Restricted deposits, at fair value (amortized cost $22,821 and $22,295, respectively)	**22,555**	22,187
Property, software and equipment, net	**67,199**	43,248
Goodwill	**157,278**	101,631
Other intangible assets, net	**17,368**	14,439
Other assets	**7,364**	5,350
Total assets	**$668,030**	$527,934
Liabilities and Stockholders' Equity		
Current liabilities:		
Medical claims liabilities	**$170,514**	$165,980
Accounts payable and accrued expenses	**29,790**	31,737
Unearned revenue	**13,648**	3,956
Current portion of long-term debt and notes payable	**699**	486
Total current liabilities	**214,651**	202,159
Long-term debt	**92,448**	46,973
Other liabilities	**8,883**	7,490
Total liabilities	**315,982**	256,622
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 42,988,230 and 41,316,122 shares, respectively	**43**	41
Additional paid-in capital	**191,840**	165,391
Accumulated other comprehensive income:		
Unrealized loss on investments, net of tax	**(1,754)**	(407)
Retained earnings	**161,919**	106,287
Total stockholders' equity	**352,048**	271,312
Total liabilities and stockholders' equity	**$668,030**	$527,934

See notes to consolidated financial statements.

Consolidated Statements of Earnings

(In thousands, except share data)	*Year Ended December 31,* 2005	2004	2003
Revenues:			
Premium	**$1,491,899**	$ 991,673	$759,763
Service	**13,965**	9,267	9,967
Total revenues	**1,505,864**	1,000,940	769,730
Expenses:			
Medical costs	**1,226,909**	800,476	626,192
Cost of services	**5,851**	8,065	8,323
General and administrative expenses	**193,913**	127,863	88,288
Total operating expenses	**1,426,673**	936,404	722,803
Earnings from operations	**79,191**	64,536	46,927
Other income (expense):			
Investment and other income	**10,655**	6,431	5,160
Interest expense	**(3,990)**	(680)	(194)
Earnings before income taxes	**85,856**	70,287	51,893
Income tax expense	**30,224**	25,975	19,504
Minority interest	**–**	–	881
Net earnings	**$ 55,632**	$ 44,312	$ 33,270
Earnings per share:			
Basic earnings per common share	**$ 1.31**	$ 1.09	$ 0.93
Diluted earnings per common share	**$ 1.24**	$ 1.02	$ 0.87
Weighted average number of shares outstanding:			
Basic	**42,312,522**	40,820,909	35,704,426
Diluted	**45,027,633**	43,616,445	38,422,152

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, 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
Net earnings	–	–	–	–	55,632	55,632
Change in unrealized investment losses, net of $(801) tax	–	–	–	(1,347)	–	(1,347)
Comprehensive earnings						54,285
Common stock issued for acquisitions	318,735	1	8,990	–	–	8,991
Common stock issued for stock options and employee stock purchase plan	1,353,373	1	6,016	–	–	6,017
Stock compensation expense	–	–	4,974	–	–	4,974
Tax benefits related to stock options	–	–	6,469	–	–	6,469
Balance, December 31, 2005	**42,988,230**	**$43**	**$191,840**	**$(1,754)**	**$161,919**	**$352,048**

See notes to consolidated financial statements.

Consolidated Statements of Cash Flows

(In thousands)	*Year Ended December 31,* 2005	2004	2003
Cash flows from operating activities:			
Net earnings	**$ 55,632**	$ 44,312	$ 33,270
Adjustments to reconcile net earnings to net cash provided by operating activities –			
Depreciation and amortization	**13,069**	10,014	6,448
Tax benefits related to stock options	**6,469**	3,316	2,366
Stock compensation expense	**4,974**	650	188
Minority interest	**–**	–	(881)
Loss (gain) on sale of investments	**70**	(138)	(1,646)
Loss on disposal of property and equipment	**454**	–	102
Deferred income taxes	**1,786**	(1,638)	772
Changes in assets and liabilities –			
Premium and related receivables	**(10,305)**	(425)	(2,364)
Other current assets	**(6,177)**	(786)	(3,180)
Other assets	**(525)**	(728)	223
Medical claims liabilities	**4,534**	34,501	15,053
Unearned revenue	**8,182**	283	3,673
Accounts payable and accrued expenses	**(4,215)**	9,951	1,531
Other operating activities	**100**	93	444
Net cash provided by operating activities	**74,048**	99,405	55,999
Cash flows from investing activities:			
Purchase of property, software and equipment	**(26,909)**	(25,009)	(19,162)
Purchase of investments	**(150,444)**	(254,358)	(435,282)
Sales and maturities of investments	**176,387**	243,623	319,564
Acquisitions, net of cash acquired	**(55,485)**	(86,739)	(5,861)
Net cash used in investing activities	**(56,451)**	(122,483)	(140,741)
Cash flows from financing activities:			
Proceeds from issuance of common stock	**–**	–	81,313
Proceeds from exercise of stock options	**5,621**	4,066	1,145
Proceeds from borrowings	**45,000**	45,860	8,581
Reduction of long-term debt and notes payable	**(4,552)**	(6,596)	(386)
Other financing activities	**(413)**	(493)	(1,221)
Net cash provided by financing activities	**45,656**	42,837	89,432
Net increase in cash and cash equivalents	**63,253**	19,759	4,690
Cash and cash equivalents, beginning of period	**84,105**	64,346	59,656
Cash and cash equivalents, end of period	**$ 147,358**	$ 84,105	$ 64,346
Interest paid	**$ 3,291**	$ 494	$ 176
Income taxes paid	**$ 31,287**	$ 20,518	$ 19,935
Supplemental schedule of non-cash investing and financing activities:			
Common stock issued for acquisitions	**$ 8,991**	$ –	$ –
Property acquired under capital leases	**$ 5,026**	$ –	$ –

See notes to consolidated financial statements.

NOTE 1. ORGANIZATION AND OPERATIONS

Centene Corporation (Centene or the Company) provides multiline healthcare 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 and states, to provide specialty services including behavioral health, disease management, nurse triage, pharmacy benefits management 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 and stockholders' equity amounts have been restated to reflect these stock splits and the increase in authorized shares.

NOTE 2. 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 includes 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 5 to 15 years. Provider contracts are amortized using the straight-line method over periods ranging from 5 to 10 years. Non-compete agreements are amortized using the straight line method over 5 years, the period of the agreement.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, the Company performs an impairment analysis of other intangible assets based on the occurrence of other factors. Such factors 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 intangible assets 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 reported but not yet paid (inventory), estimates for claims incurred but not yet received (IBNR) 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, 2005; 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 under contracts with state and local government entities, our health plans and third-party customers. Revenues for services are recognized when the services are provided or as ratably earned over the covered period of services. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Such amounts are recorded as unearned revenue.

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. Activity in the allowance for uncollectible accounts for the years ended December 31 is summarized below:

	2005	2004	2003
Allowances, beginning of year	**$ 462**	$ 607	$219
Amounts charged to expense	**80**	407	472
Write-offs of uncollectible receivables	**(199)**	(552)	(84)
Allowances, end of year	**$ 343**	$ 462	$607

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, 2006 and August 31, 2008, are expected to be renewed. Contracts with the states of Indiana, Kansas, Texas and Wisconsin each accounted for 18%, 12%, 22% and 23%, respectively, of the Company's revenues for the year ended December 31, 2005.

Reinsurance

Centene has purchased reinsurance from third parties to cover eligible healthcare services. The current reinsurance program covers 90% of inpatient healthcare expenses in excess of annual deductibles of $300 per member, up to a lifetime maximum of $2,000. Centene's Medicaid Managed Care subsidiaries are responsible for inpatient charges in excess of an average daily per diem.

Reinsurance recoveries were $4,014, $3,730, and $5,345, in 2005, 2004, and 2003, respectively. Reinsurance expenses were approximately $4,105, $6,724, and $6,185 in 2005, 2004, and 2003, 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.

Interest expense relates to borrowings under our credit facility, mortgage interest, interest on capital leases 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.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of

existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Stock Based Compensation

The Company accounts for stock based compensation plans under APB Opinion No. 25 "Accounting for Stock Issued to Employees." 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 following table illustrates the effect on net earnings and earnings per share if a fair value based method applied to all awards.

	2005	2004	2003
Net earnings	**$ 55,632**	$44,312	$33,270
Stock-based employee compensation expense included in net earnings, net of related tax effects	**3,084**	403	117
Stock-based employee compensation expense determined under fair value based method, net of related tax effects	**(11,988)**	(3,893)	(2,378)
Pro forma net earnings	**$ 46,728**	$40,822	$31,009
Basic earnings per common share:			
As reported	**$ 1.31**	$ 1.09	$ 0.93
Pro forma	**1.10**	1.00	0.87
Diluted earnings per common share:			
As reported	**$ 1.24**	$ 1.02	$ 0.87
Pro forma	**1.05**	0.94	0.81

In October 2005 the Compensation Committee approved the immediate and full acceleration of vesting of 260,000 "out-of-the-money" stock options to certain employees. These employees did not include any of the Company's executive officers or other employees at Vice President level or above. Each stock option issued as a part of these grants has an exercise price greater than the closing price per share on the date of the Compensation Committee's action. The purpose of the acceleration is to enable the Company to avoid recognizing compensation expense associated with these options in future periods in our consolidated statements of earnings, as a result of SFAS 123R. The pre-tax charge to be avoided totals approximately $3.0 million which would have been recognized over the years 2006, 2007, 2008 and 2009. This amount is reflected in the pro forma disclosures included above. The options that have been accelerated have an exercise price in excess of the current market value of our common stock, and, accordingly, the Compensation Committee determined that the expense savings outweighs the objective of incentive compensation and retention.

Additional information regarding the stock option plans is included in Note 12.

Reclassifications

Certain amounts in the consolidated financial statements have been reclassified to conform to the 2005 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Recent Accounting Pronouncements

In December 2004, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards No. 123 (revised 2004), "Share Based Payment," (SFAS 123R). SFAS 123R establishes the accounting for transactions in which an entity obtains employee services in share-based payment transactions. SFAS 123R requires public companies 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. The Company will adopt SFAS 123R effective January 1, 2006, using the modified-prospective method, and expects the 2006 effect to decrease diluted earnings per share by approximately $0.15.

NOTE 3. ACQUISITIONS

AirLogix

Effective July 22, 2005, the Company acquired AirLogix, Inc., a disease management provider. The Company paid approximately $36,200 in cash and related transaction costs. If certain performance criteria are achieved, additional consideration of up to $5,000 may be paid. The results of operations for AirLogix are included in the consolidated financial statements since July 22, 2005.

The preliminary purchase price allocation resulted in estimated identified intangible assets of $5,000 and associated deferred tax liabilities of $1,900, and goodwill of approximately $30,100. The identifiable intangible assets have an estimated useful life of five years. The acquired goodwill is not deductible for income tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

SummaCare

Effective May 1, 2005, the Company acquired certain Medicaid-related assets from SummaCare, Inc. for a purchase price of approximately $30,400. The purchase price and related transaction costs consisted of approximately $21,400 in cash and 318,735 shares of common stock valued at approximately $9,000. The cost to acquire the Medicaid-related assets has been preliminarily allocated to the assets acquired and liabilities assumed according to estimated fair values. The results of operations for SummaCare are included in the consolidated financial statements since May 1, 2005.

The preliminary purchase price allocation resulted in identified intangible assets of $550, representing purchased contract rights and provider contracts and goodwill of approximately $29,900. The identified intangible assets are being amortized over periods ranging from 5 to 10 years. The acquired goodwill is deductible for income tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

FirstGuard

The Company purchased FirstGuard, Inc. and FirstGuard Health Plan, Inc. from Swope Community Enterprises (Swope) effective December 1, 2004. Centene paid $96,020 in cash and related transaction costs. 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 estimated fair value of the net tangible assets acquired by approximately $91,920. The Company has allocated the excess purchase price over the fair value of the net tangible assets acquired to identifiable intangible assets of $7,800, representing purchased contract rights and associated deferred tax liabilities of $2,977, and goodwill of approximately $87,097. The purchased contract rights have an estimated useful life ranging from 10 to 15 years. The acquired goodwill is not deductible for income tax purposes. The final estimate of the fair value of the tangible assets/(liabilities) as of the acquisition date 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	(7,057)
Due to seller	(28,741)
Net tangible assets acquired	$ 4,100

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 earnings per common 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 contracts 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 $3,315. 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.

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.

NOTE 4. 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, 2005 consist of the following:

	December 31, 2005			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of				
U.S. government corporations and agencies	$ 38,648	$32	$ (660)	$ 38,020
Corporate securities	98,508	20	(1,368)	97,160
State and municipal securities	58,446	18	(849)	57,615
Life insurance contracts	10,121	–	–	10,121
Total	$205,723	$70	$(2,877)	$202,916

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**

The Company monitors investments for other than temporary impairment. Certain investments have experienced a decline in market value due to changes in market interest rates. Based on the credit quality of the investments and our ability to hold these investments to recovery (which may be maturity), no other than temporary impairment has been recorded. Investments in a gross unrealized loss position at December 31, 2005 are as follows:

		Less Than 12 Months		*12 Months or More*		*Total*	
	Amortized Cost	Unrealized Losses	Market Value	Unrealized Losses	Market Value	Unrealized Losses	Market Value
Corporate	$ 67,549	$(313)	$ 26,151	$(1,055)	$40,030	$(1,368)	$ 66,181
Government	36,472	(110)	13,309	(549)	22,504	(659)	35,813
Municipal	53,343	(196)	27,646	(654)	24,847	(850)	52,493
Total	$157,364	$(619)	$67,106	$(2,258)	$87,381	$(2,877)	$154,487

Investments in a gross unrealized loss position at December 31, 2004 are as follows:

		Less Than 12 Months		*12 Months or More*		*Total*	
	Amortized Cost	Unrealized Losses	Market Value	Unrealized Losses	Market Value	Unrealized Losses	Market Value
Corporate	$ 67,079	$ (477)	$ 66,602	$ –	$ –	$ (477)	$ 66,602
Government	52,087	(319)	51,768	–	–	(319)	51,768
Municipal	46,284	(290)	43,555	(46)	2,393	(336)	45,948
Total	$165,450	$(1,086)	$161,925	$(46)	$2,393	$(1,132)	$164,318

The contractual maturities of short-term and long-term investments and restricted deposits as of December 31, 2005, are as follows:

	Investments		Restricted Deposits	
	Amortized Cost	Estimated Market Value	Amortized Cost	Estimated Market Value
One year or less	$ 56,863	$ 56,700	$16,681	$16,532
One year through five years	112,623	110,311	5,310	5,177
Five years through ten years	13,416	13,350	830	846
Total	$182,902	$ 180,361	$22,821	$22,555

The contractual maturities 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:

	2005	2004	2003
Gross realized gains	$ –	$ 861	$1,859
Gross realized losses	(70)	(723)	(213)
Net realized (losses) gains	$(70)	$ 138	$1,646

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 $22,555 and $22,187 were deposited or pledged to state agencies by Centene's managed care subsidiaries at December 31, 2005 and 2004, respectively. These investments are classified as long-term restricted deposits in the consolidated financial statements due to the nature of the states' requirements.

NOTE 5. PROPERTY, SOFTWARE AND EQUIPMENT

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

	2005	2004
Building	$ 25,376	$ 13,649
Computer software	21,510	10,976
Land	11,815	13,129
Computer hardware	11,717	7,052
Furniture and office equipment	10,163	6,197
Leasehold improvements	6,125	4,321
	86,706	55,324
Less accumulated depreciation	(19,507)	(12,076)
Property, software and equipment, net	$ 67,199	$ 43,248

Depreciation expense for the years ended December 31, 2005, 2004 and 2003 was $8,134, $5,149 and $3,469, respectively.

NOTE 6. INTANGIBLE ASSETS

Goodwill balances and the changes therein are as follows:

	Medicaid Managed Care	Specialty Services	Total
Balance as of December 31, 2003	$ 9,171	$ 3,895	$ 13,066
Acquisitions	89,988	(124)	89,864
Deferred tax asset recognition	(1,268)	(31)	(1,299)
Balance as of December 31, 2004	97,891	3,740	101,631
Acquisitions	30,158	30,033	60,191
Deferred tax asset recognition	(4,159)	(385)	(4,544)
Balance as of December 31, 2005	$123,890	$33,388	$157,278

Goodwill reductions in 2005 and 2004 were related to the recognition of acquired net operating loss carryforward benefits.

Other intangible assets at December 31 consist of the following:

	2005	2004	Weighted Average Life in Years 2005	2004
Purchased contract rights	$14,543	$ 7,318	11.1	7.2
Provider contracts	3,021	1,900	10.0	10.0
Non-compete agreements	300	300	5.0	5.0
Estimated identifiable intangibles	5,000	8,000	5.0	10.0
Other intangible assets	22,864	17,518	10.0	7.8
Less accumulated amortization:				
Purchased contract rights	(4,305)	(2,611)		
Provider contracts	(654)	(342)		
Non-compete agreements	(120)	(60)		
Estimated identifiable intangibles	(417)	(66)		
Total accumulated amortization	(5,496)	(3,079)		
Other intangible assets, net	$17,368	$14,439		

Amortization expense was $2,416, $1,481 and $986 for the years ended December 31, 2005, 2004 and 2003, respectively. The estimated amortization expense for 2006, 2007, 2008, 2009 and 2010, assuming no further acquisitions, is approximately $2,800, $2,800, $2,500, $2,200 and $1,700, respectively.

NOTE 7. INCOME TAXES

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

	2005	2004	2003
Current provision:			
Federal	$26,884	$23,652	$16,776
State and local	1,661	3,038	2,464
Total current provision	28,545	26,690	19,240
Deferred provision	1,679	(715)	264
Total provision for income taxes	$30,224	$25,975	$19,504

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

	2005	2004	2003
Tax provision at the U.S. federal statutory rate	$30,050	$24,600	$18,163
State income taxes, net of federal income tax benefit	1,230	1,975	1,602
Other, net	(1,056)	(600)	(261)
Income tax expense	$30,224	$25,975	$19,504

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

	2005	2004
Deferred tax assets:		
Medical claims liabilities	$ 1,383	$ 5,086
Unearned premium and other deferred revenue	4,890	304
Unrealized loss on investments	1,053	312
Federal net operating loss carry forward	5,452	4,219
State net operating loss carry forward	3,205	1,845
Stock compensation	2,126	243
Other	2,675	3,542
Total gross deferred tax assets	20,784	15,551
Deferred tax liabilities:		
Intangible assets	6,202	4,286
Prepaid assets	1,621	1,027
Depreciation and amortization	4,864	839
Total gross deferred tax liabilities	12,687	6,152
Valuation allowance	(2,772)	(6,064)
Net deferred tax assets	$ 5,325	$ 3,335

The Company's deferred tax assets include federal and state net operating losses (NOLs), the majority of which were acquired in business combinations. Accordingly, the total and annual deduction for those NOLs is limited by tax law. The federal NOLs expire between the years 2011 and 2024 and the state NOLs expire between the years 2006 and 2026. Valuation allowances are recorded for those NOLs the Company believes are more-likely-than-not to expire unused. During 2005 and 2004, the Company recorded valuation allowance reductions of $5,340 and $1,745, respectively, and recorded additional valuation allowances of $2,048 and $255, respectively. The 2005 and 2004 tax provision included $790 and $273 of the valuation allowance reductions. The remainder was recorded as a reduction of goodwill and other intangible assets. The net deferred tax assets and liabilities are reflected on the consolidated balance sheets in other current assets and other liabilities.

NOTE 8. MEDICAL CLAIMS LIABILITIES

The change in medical claims liabilities is summarized as follows:

	2005	2004	2003
Balance, January 1	**$ 165,980**	$106,569	$ 91,181
Acquisitions	**–**	24,909	335
Incurred related to:			
Current year	**1,244,600**	816,418	645,482
Prior years	**(17,691)**	(15,942)	(19,290)
Total incurred	**1,226,909**	800,476	626,192
Paid related to:			
Current year	**1,075,204**	681,780	544,309
Prior years	**147,171**	84,194	66,830
Total paid	**1,222,375**	765,974	611,139
Balance, December 31	**$ 170,514**	$165,980	$106,569

Changes in estimates of incurred claims for prior years were attributable to favorable development, including changes in medical utilization and cost trends.

The Company had reinsurance recoverables related to medical claims liabilities of $261 and $953 at December 31, 2005 and 2004, respectively, included in premium and related receivables.

NOTE 9. DEBT

Debt consists of the following at December 31:

	2005	2004
Revolving line of credit	**$75,000**	$34,000
Mortgage notes payable	**12,974**	13,459
Capital leases	**5,173**	–
Total debt	**93,147**	47,459
Less current maturities	**(699)**	(486)
Long-term debt	**$92,448**	$46,973

In September 2005, the Company executed an amendment to the five-year Revolving Credit Agreement dated September 14, 2004, with various financial institutions, for which LaSalle Bank National Association serves as administrative agent and co-lead arranger. The amendment increased the total amount available under the credit agreement to $200,000 from $100,000, including a sub-facility for letters of credit in an aggregate amount up to $50,000. In addition, under the amendment the lending institutions released the Company's prior grant of a security interest in the outstanding common stock and membership interests of each of the Company's subsidiaries. The credit agreement is now an unsecured facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.225% to 0.35% depending on the total debt-to-EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2010 or on an earlier date in the instance of a default as defined in the agreement. At December 31, 2005, the outstanding borrowings totaled $75,000 bearing interest at a weighted average composite of 5.7% and outstanding letters of credit totaled $15,000.

Mortgage notes payable consists of two mortgages collateralized by the Company's headquarters property. The mortgages bear interest at the prevailing prime rate less .75%. (6.5% at December 31, 2005). The respective properties had a net book value of $21,858 at December 31, 2005. The mortgages include a financial covenant requiring a minimum rolling twelve-month debt service coverage ratio. As of December 31, 2005, the Company was in compliance with this covenant.

Capital leases consist of office equipment and building facilities with a weighted average composite interest rate of 5.4%.

Aggregate maturities for the Company's debt are as follows:

2006	$ 699
2007	684
2008	692
2009	638
2010	86,184
Thereafter	4,250
Total	$93,147

NOTE 10. STOCKHOLDERS' EQUITY

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

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2005, there were no preferred shares outstanding.

In November 2005, the Company's board of directors adopted a stock repurchase program authorizing the Company to repurchase up to 4,000,000 shares of common stock from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 31, 2007, but the Company reserves the right to suspend or discontinue the program at anytime. During the year ended December 31, 2005, the Company did not repurchase any shares through this program.

NOTE 11. STATUTORY CAPITAL REQUIREMENTS AND DIVIDEND RESTRICTIONS

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2005 and 2004, Centene's subsidiaries had aggregate statutory capital and surplus of $183,500 and $123,600, respectively, compared with the required minimum aggregate statutory capital and surplus of $87,700 and $65,100, respectively. The Company received dividends from its managed care subsidiaries of $7,000, $0 and $6,000 during the years ended December 31, 2005, 2004 and 2003, respectively.

NOTE 12. 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 the date of grant. The Plans have 790,769 shares available for future awards. Options granted generally vest over a three or 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:

	2005		2004		2003	
	Shares	Weighted Average Exercise Price	Shares	Weighted Average Exercise Price	Shares	Weighted Average Exercise Price
Options outstanding, beginning of year	6,183,016	$11.78	5,438,058	$ 6.91	4,665,420	$ 3.13
Granted	775,500	26.41	2,006,500	20.86	1,992,578	13.00
Exercised	(1,315,743)	3.70	(1,003,098)	3.76	(877,786)	1.13
Canceled	(369,202)	14.07	(258,444)	10.63	(342,154)	5.77
Options outstanding, end of year	5,273,571	$15.79	6,183,016	$11.78	5,438,058	$ 6.91
Weighted average remaining life	7.7 years		7.8 years		7.6 years	
Weighted average fair value of options granted	$13.77		$12.25		$7.63	

The following table summarizes information about options outstanding as of December 31, 2005:

	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	519,950	4.0	$ 0.56	505,850	$ 0.54
$ 2.50 - $ 4.99	31,978	6.1	4.67	13,978	4.67
$ 5.00 - $9.99	786,664	6.3	7.80	400,564	7.65
$10.00 -$14.99	1,357,793	7.7	13.30	514,366	13.30
$15.00 -$19.99	1,022,686	8.4	17.52	241,053	17.30
$20.00 -$24.99	112,500	9.5	23.65	7,400	22.34
$25.00 -$29.99	1,314,500	9.3	25.82	350,100	26.07
$30.00 -$34.99	127,500	9.4	32.47	11,000	33.90
	5,273,571	7.7	$15.79	2,044,311	$11.78

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 47%, 57% and 53%; risk-free interest rate of 4.3%, 3.7% and 3.1% and expected lives of 6.4, 6.0 and 6.0 for the years ended December 31, 2005, 2004 and 2003, respectively.

In 2005 the Company granted 12,905 shares of restricted stock with a grant date fair market value per share of $29.05 with full vesting in 2006 and 140,750 shares of restricted stock units with a weighted average market value per share of $29.15. Restricted stock units granted generally vest over a three or five-year period beginning on the first anniversary of the date of grant and annually thereafter.

In 2004 the Company granted 1,000,000 restricted stock units with a grant date fair market value per share of $24.60. These 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 45,497 shares, 20,676 shares, and 18,428 shares in 2005, 2004 and 2003, respectively, related to the employee stock purchase plan.

NOTE 13. 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 $1,124, $822 and $581 during the years ended December 31, 2005, 2004 and 2003, respectively.

NOTE 14. COMMITMENTS

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Rent expense was $7,623, $5,482 and $3,144 for the years ended December 31, 2005, 2004 and 2003, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows:

2006	$ 9,210
2007	8,969
2008	7,151
2009	6,202
2010	5,242
Thereafter	9,741
	$46,515

NOTE 15. CONTINGENCIES

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.

NOTE 16. EARNINGS PER SHARE

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

	2005	2004	2003
Net earnings	**$55,632**	$44,312	$33,270
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	**42,312,522**	40,820,909	35,704,426
Common stock equivalents (as determined by applying the treasury stock method)	**2,715,111**	2,795,536	2,717,726
Weighted average number of common shares and potential dilutive common shares outstanding	**45,027,633**	43,616,445	38,422,152
Basic earnings per common share	**$ 1.31**	$ 1.09	$ 0.93
Diluted earnings per common share	**$ 1.24**	$ 1.02	$ 0.87

The calculation of diluted earnings per common share for 2005, 2004 and 2003 excludes the impact of 328,250, 0 and 1,317,820 shares, respectively, related to stock options, unvested restricted stock and restricted stock units which are anti-dilutive.

NOTE 17. 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, disease management, 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, 2005, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$1,445,533	$60,331	$ –	$1,505,864
Revenue from internal customers	71,967	37,374	(109,341)	–
Total revenue	$1,517,500	$97,705	$(109,341)	$1,505,864
Earnings from operations	$ 79,189	$ 2	$ –	$ 79,191
Total assets	$ 645,409	$22,621	$ –	$ 668,030
Depreciation expense	$ 7,723	$ 411	$ –	$8,134
Capital expenditures	$ 25,146	$ 1,763	$ –	$ 26,909

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 from operations	$ 66,084	$ (1,548)	$ –	$ 64,536
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 from operations	$ 44,811	$ 2,116	$ –	$ 46,927
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 2.

NOTE 18. COMPREHENSIVE EARNINGS

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

Year Ended December 31,	2005	2004
Net earnings	$55,632	$44,312
Reclassification adjustment, net of tax	138	(466)
Change in unrealized losses on investments available for sale, net of tax	(1,485)	(681)
Total comprehensive earnings	$54,285	$43,165

NOTE 19. SUBSEQUENT EVENTS

US Script

In January 2006, the Company acquired US Script, Inc., a pharmacy benefits manager. The purchase price of approximately $40,000 plus transaction costs will be allocated to the assets acquired and liabilities assumed according to estimated fair values. In accordance with the terms of the agreement, the Company may pay up to an additional $10,000 if US Script, Inc. achieves certain earnings targets over a five-year period.

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.

Our financial statements 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 Securities Exchange Act Rules 13a-15(f) and 15d-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, 2005. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2005 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Management has excluded AirLogix, Inc. from its assessment of internal control over financial reporting as of December 31, 2005 because AirLogix was acquired by the Company in a purchase business combination effective July 22, 2005. AirLogix is a wholly owned subsidiary whose total assets and total revenues represent 6.6% and 0.5%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2005.

Other Information

We included as Exhibits 31.1 and 31.2 to our Annual Report on Form 10-K for fiscal year 2005 filed with the Securities and Exchange Commission certificates of our Chairman and Chief Executive Officer and our Chief Financial Officer, certifying the quality of our public disclosure. We submitted to the New York Stock Exchange a certificate of our Chairman and Chief Executive Officer certifying, for the prior fiscal year, that he is not aware of any violation by us of New York Stock Exchange corporate governance listing standards.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
Centene Corporation:

We have audited management's assessment, included in the accompanying Management's Report on Internal Control over Financial Reporting, that Centene Corporation (the Company) maintained effective internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (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 an opinion on management's assessment and an opinion on the effectiveness of the Company's internal control over financial reporting based on our audit.

We conducted our audit 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. Our audit included 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 considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

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 (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) 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 (3) 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.

In our opinion, management's assessment that Centene Corporation maintained effective internal control over financial reporting as of December 31, 2005, is fairly stated, in all material respects, based on the criteria established in *Internal Control – Integrated Framework* issued by COSO. Also, in our opinion, Centene Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control – Integrated Framework* issued by COSO.

Centene Corporation acquired AirLogix, Inc. during 2005, and management excluded from its assessment of the effectiveness of Centene Corporation's internal control over financial reporting as of December 31, 2005, AirLogix, Inc.'s internal control over financial reporting associated with total assets of $44.0 million and total revenues of $8.2 million included in the consolidated financial statements of Centene Corporation and subsidiaries as of and for the year ended December 31, 2005. Our audit of internal control over financial reporting of Centene Corporation also excluded an evaluation of the internal control over financial reporting of AirLogix, Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheet of Centene Corporation and subsidiaries as of December 31, 2005, and the related consolidated statements of earnings, stockholders' equity, and cash flows for the year ended December 31, 2005, and our report dated February 23, 2006, expressed an unqualified opinion on those consolidated financial statements.

KPMG LLP

St. Louis, Missouri
February 23, 2006

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
Centene Corporation:

We have audited the accompanying consolidated balance sheet of Centene Corporation and subsidiaries as of December 31, 2005 and the related consolidated statements of earnings, stockholders' equity, and cash flows for the year ended December 31, 2005. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audit.

We conducted our audit 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2005 and the results of their operations and their cash flows for the year ended December 31, 2005, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of internal control over financial reporting of Centene Corporation as of December 31, 2005, based on the criteria established in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 23, 2006 expressed an unqualified opinion on management's assessment of, and the effective operation of, internal control over financial reporting.

KPMG LLP

St. Louis, Missouri
February 23, 2006

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

In our opinion, the accompanying consolidated balance sheet as of December 31, 2004 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 the results of their operations and their cash flows for each of the two 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.

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

Robert K. Ditmore
Former President and COO
UnitedHealthcare Corporation

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

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

Tommy G. Thompson
Former HHS Secretary and
Former Governor of Wisconsin

SENIOR MANAGEMENT

Michael F. Neidorff
Chairman and CEO

Joseph P. Drozda, Jr., M.D.
Executive VP and Chief Medical Officer

Marie J. Glancy
Sr. VP, Operational Services and Regulatory Affairs

Carol E. Goldman
Sr. VP and Chief Administrative Officer

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

Robert C. Packman, M.D.
Sr. VP, Medical Affairs

William N. Scheffel
Sr. VP, Specialty Companies

Glendon A. Schuster
VP and Chief Information Officer

Joy D. Wheeler
Sr. VP, Health Plan Business Unit Development

Lisa M. Wilson
Sr. VP, Investor Relations

Karey L. Witty
Sr. VP and Chief Financial Officer

FIELD OFFICERS

William E. Baker, Jr.
COO, Superior HealthPlan

Christopher D. Bowers
Regional VP, (Superior HealthPlan and FirstGuard)
CEO and President, Superior HealthPlan

Kathleen R. Crampton
President and COO, Buckeye Community Health Plan

Patricia J. Darnley
Regional VP (University Health Plans and MHS Wisconsin)

Stephanie E. DeKemper
President, Centene Foundation for Quality Healthcare

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

Mary C. Garcia
COO, University Health Plans

Rita F. Johnson-Mills
Regional VP and CEO (MHS Indiana and Buckeye)

Linda A. McKnew
President and CEO, MHS Wisconsin

David J. McNichols
President, CEO and Chairman
Peach State Health Plan

Jean E. Rumbaugh
President, FirstGuard

Kimberly D. Tuck
President and CEO, NurseWise and ScriptAssist

Amy N. Williams
President and COO, MHS Indiana

OFFICERS

Bruce Barter, M.D.
VP, Medical Affairs, CenCorp Health Solutions

Judy A. Bauer
VP, Care Management

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

J. Per Brodin
VP, Chief Accounting Officer

Brian R. Butts
VP, Finance, CenCorp Health Solutions

Julia A. Ciorletti
VP, Government Relations

David R. Craig
VP, Transportation Services

Karen A. Fain
VP, Internal Audit

Richard L. Fredrickson
VP, SSI and Special Care Programs

Stephanie A. Hall
VP, Human Resources – Health Plans

Debra A. Halladay
VP, Contracting and Network Development

Jesse N. Hunter
VP, Mergers and Acquisitions

Cynthia P. Jansky
VP, Human Resources

Michael G. Josias
VP, Organizational Development and Training

Leon J. Luttschwager
VP, Operations and Business Processes
CenCorp Health Solutions

Charles S. Mangene
VP, Health and Claims Information Systems

Angelia S. Milhous
VP, Operational Services

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

Kristie M. Whitmore
VP, Claims Operations, Missouri

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, 2005, 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 is traded and quoted on the New York Stock Exchange under the symbol "CNC."

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.

		High	Low
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
2005	**First Quarter**	**$35.38**	**$26.50**
	Second Quarter	**34.38**	**24.86**
	Third Quarter	**37.91**	**22.60**
	Fourth Quarter	**27.76**	**16.76**

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 Stockholders will be held on Tuesday, April 25, 2006, 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

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