



INTERCOMMUNITY HEALTH PLANS, INC.

Financial Statements

December 31, 2014 and 2013

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 3800
1300 South West Fifth Avenue
Portland, OR 97201

Independent Auditors' Report

The Board of Directors
Intercommunity Health Plans, Inc.
Corvallis, Oregon:

We have audited the accompanying financial statements of Intercommunity Health Plans, Inc. (the Network), which comprise the balance sheets as of December 31, 2014 and 2013, and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Intercommunity Health Plans, Inc. as of December 31, 2014 and 2013, and the results of its operations and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

March 27, 2015

INTERCOMMUNITY HEALTH PLANS, INC.

Balance Sheets

December 31, 2014 and 2013

Assets	2014	2013
Current assets:		
Cash	\$ 67,903,086	22,400,822
Short-term investments	3,727,563	1,157,444
Maternity receivable	2,636,859	1,774,082
Other receivables	59,091	100,274
Other current assets	588,582	131,651
Total current assets	74,915,181	25,564,273
Statutory deposits	5,824,514	2,999,521
Investments	3,222,203	5,691,165
Property, plant, and equipment, net	17,448	—
Total assets	\$ 83,979,346	34,254,959
Liabilities and Net Assets		
Current liabilities:		
Accounts payable	\$ 570,049	2,054,782
Liability for unpaid medical claims	38,595,555	15,179,242
Accounts payable to affiliates	4,547,027	2,756,708
Risk pool distributions payable	5,254,613	1,983,909
Deferred revenue	6,235,396	6,061,180
Other current liabilities	5,618,676	—
Total current liabilities	60,821,316	28,035,821
Other liabilities	125,000	—
Total liabilities	60,946,316	28,035,821
Net assets:		
Unrestricted net assets	23,033,030	6,219,138
Total net assets	23,033,030	6,219,138
Total liabilities and net assets	\$ 83,979,346	34,254,959

See accompanying notes to financial statements.

INTERCOMMUNITY HEALTH PLANS, INC.

Statements of Operations and Changes in Net Assets

Years ended December 31, 2014 and 2013

	2014	2013
Revenues:		
Capitation revenue, net	\$ 254,589,852	127,923,816
Interest and dividend income	351,721	187,701
Grants	1,273,950	—
Total revenues	256,215,523	128,111,517
Expenses:		
Medical services	221,750,652	116,311,467
Administration:		
Salaries, wages, and benefits	7,920,133	4,848,830
Claims processing	3,186,083	1,245,616
Premium tax	—	1,132,653
Depreciation	9,862	—
Insurance	103,676	88,083
Supplies and other	6,432,803	941,418
Total administration expenses	17,652,557	8,256,600
Total expenses	239,403,209	124,568,067
Excess of revenues over expenses	16,812,314	3,543,450
Change in net unrealized gains and losses on investments	1,578	(28,736)
Change in net assets	16,813,892	3,514,714
Net assets, beginning of year	6,219,138	2,704,424
Net assets, end of year	\$ 23,033,030	6,219,138

See accompanying notes to financial statements.

INTERCOMMUNITY HEALTH PLANS, INC.

Statements of Cash Flows

Years ended December 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Cash flows from operating activities:		
Change in net assets	\$ 16,813,892	3,514,714
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	9,862	—
Net realized and unrealized losses (gains) on investments	(1,578)	28,736
Changes in operating assets and liabilities:		
Maternity receivable	(862,777)	295,549
Other receivables	41,183	(26,398)
Other current assets	(456,931)	(44,376)
Accounts payable	(1,484,733)	1,653,914
Liability for unpaid medical claims	23,416,313	341,762
Accounts payable to affiliates	1,790,319	1,641,359
Risk pool distributions payable	3,270,704	823,009
Premium tax payable	—	(389,696)
Deferred revenue	174,216	4,733,046
Other current liabilities	5,618,676	—
Other liabilities	125,000	—
Net cash provided by operating activities	<u>48,454,146</u>	<u>12,571,619</u>
Cash flows from investing activities:		
Purchase of investments	(6,943,205)	(10,750,540)
Proceeds from sale or maturity of investments	4,018,633	9,541,299
Purchase of property, plant, and equipment	(27,310)	—
Net cash used in investing activities	<u>(2,951,882)</u>	<u>(1,209,241)</u>
Net change in cash and cash equivalents	45,502,264	11,362,378
Cash, beginning of year	<u>22,400,822</u>	<u>11,038,444</u>
Cash, end of year	<u>\$ 67,903,086</u>	<u>22,400,822</u>

See accompanying notes to financial statements.

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

(1) Description of Organization and Summary of Significant Accounting Policies

(a) *Organization*

Intercommunity Health Plans, Inc. (the Network) is an Oregon nonprofit corporation, incorporated on April 30, 1993. The Network began operations on February 1, 1994. Samaritan Health Services, Inc. (SHS) is the sole corporate member of the Network.

The Network administers healthcare benefits to certain members of the Oregon Health Plan, placing emphasis on preventative medicine and health education programs for the benefit of the members. During 2012, the Network was selected to provide the infrastructure and delivery system for a community Coordinated Care Organization (CCO). In August 2012, this CCO took over for the previous Medicaid plan managed by the Network. The Network had 55,601 and 35,627 members at December 31, 2014 and 2013, respectively.

As a condition of operating as a risk contractor with the State of Oregon in the Medicaid program, the Network is subject to regulatory requirements that require the Network to establish and maintain a restricted reserve fund and a minimum level of net worth.

The Network contracts for healthcare services with multiple provider types such as hospitals, multispecialty and primary care physician organizations and other providers in the Willamette Valley and mid-Oregon coast, including those owned or managed by SHS (collectively, SHS Providers), for the provision of medical services to its members. These contracts provide for payment to providers based upon a variety of per diem, fee-for-service or monthly capitation arrangements.

(b) *Use of Estimates*

The preparation of financial statements in conformity with U.S. 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. Significant items subject to such estimates include maternity receivable, reinsurance receivable, liability for unpaid medical claims and risk pool distributions payable. Actual results could differ significantly from those estimates.

(c) *Investments*

Investments in debt securities are measured at fair value in the balance sheets. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or by law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities.

An impairment of a fixed-income security that is deemed to be other than temporary is allocated between the credit and noncredit portion and included in excess of revenues over expenses and changes in net assets, respectively. A new cost basis is then established for the security. The basis for securities sold is determined using the specific-identification method.

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

Investments include cash equivalents, which include investments in highly liquid investments with original maturities of three months or less and are not included in operating cash.

(d) *Capitation Revenue, Maternity Receivable, and Deferred Revenue*

Capitation revenue is derived from payments received from the State of Oregon based on the number of members who qualify for enrollment in the Network's service area under the Oregon Health Plan. Capitation revenue also includes case rate reimbursement from the State of Oregon for infant deliveries by members. Capitation revenues are recognized in the period in which services are covered. The Network records a maternity receivable for any unpaid maternity case rates for deliveries occurring as of December 31, 2014 and 2013.

During 2014 and 2013, a specific component of the capitation revenue from the State of Oregon for the CCO membership is intended to support a range of healthcare transformation initiatives. The Network is recognizing this revenue as the specifically identified transformation expenses related to this revenue are incurred. Deferred revenue includes transformation related capitation revenue that has not been spent on such initiatives prior to December 31, 2014 and 2013. The Network recorded transformation related capitation revenue of \$2,984,929 during 2014 and \$488,000 during 2013.

The continuance of the Oregon Health Plan is dependent upon governmental policies and funding.

During 2014, the Network received \$2,123,653 in state grant funds. As of December 31, 2014 and 2013, the state grants deferred revenue balance was \$849,703 and \$0, respectively, and was included in deferred revenue in the accompanying statements of net position. The balance in deferred revenue as of year-end represents amounts advanced for which the Network has not yet met all applicable eligibility requirements. Revenue and expense recognized under these grants was \$1,273,950 and \$0, respectively, in 2014 and 2013.

(e) *Reinsurance*

Reinsurance limits the cost to the Network of medical services for members whose healthcare costs exceed a specified level. The Network remains obligated for amounts ceded in the event that reinsurers do not meet their obligations. Ceded reinsurance transactions are accounted for based on estimates of their ultimate cost. Reinsurance premiums are reported as a medical services expense, and recoveries are reported as a reduction of medical services expense in the statements of operations and changes in net assets.

(f) *Premium Deficiency Reserves*

Premium deficiency reserves and the related expense are recognized when it is probable that expected future healthcare costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the remaining periods of the contracts. Investment income is considered in management's evaluation of premium deficiency reserves. The methods for making such estimates and for establishing resulting reserves are continually reviewed and updated, and any adjustments are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. At December 31, 2014 and 2013, management believes that no premium deficiency reserve is required.

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

(g) *Liability for Unpaid Medical Claims*

The cost of healthcare services is recognized in the period in which services are provided. The reserve for unpaid medical claims includes an estimate of the cost of services that have been incurred but not reported. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims data. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of paid claims is dependent on future developments, management is of the opinion that the reserves for claims are adequate to cover such claims.

The Network recorded an increase in medical services expense for which there was insufficient estimated expense for unpaid medical claims of \$(3,009,665) in 2014 related to prior year claims. In 2013, the Network recorded a decrease in medical services expense for which there was excess estimated liability for unpaid medical claims of \$324,000 related to prior years.

(h) *Accounts Payable to Affiliates*

The Network's contracts with SHS Providers provide for claims payment on a fee-for-service basis. Certain other intercompany activity with the SHS Providers is included in accounts payable to affiliates and described in note 5.

(i) *Risk Pool Distributions Payable*

Risk pool distributions payable represent the estimated settlement amounts due to organizations per risk contract agreements.

(j) *Excess of Revenues over Expenses*

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in net assets that are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities.

(k) *Premium Tax*

Effective May 1, 2004, the State of Oregon legislature implemented a tax on certain managed care health services organizations in the state. The tax was sunset October 1, 2013. The tax rate was 1.0% on managed care premiums received during 2013. Premium tax was recognized as expense during the month for which the premium is earned.

Effective October 1, 2009, the Network was subject to pass-through payments from the State of Oregon to designated hospitals. These funds were excluded from the statements of operations and changes in net assets. The funds were recorded as a liability on the balance sheets if the funds were received from the State of Oregon and not yet forwarded to the recipient hospital as of the period-end. This program was sunset September 30, 2013. The Network recorded a liability of \$0 and \$278,000 at December 31, 2014 and 2013, respectively, which are included in accounts payable in the balance sheets.

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

(1) Income Taxes

The Network is exempt from taxation under Section 501(c)(4) of the Internal Revenue Code and is generally not subject to federal or state income taxes.

The Network is subject to income taxes on any net income that is derived from a trade or business, regularly carried on, and not in furtherance of the purposes for which it was granted exemption. No income tax provision has been recorded as the net income, if any, from any unrelated trade or business is, in the opinion of management, not material to the financial statements taken as a whole.

U.S. generally accepted accounting principles require the Network's management to evaluate tax positions and recognize a tax liability (or asset) if the Network has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. Management has analyzed tax positions taken by the Network and has concluded that as of December 31, 2014, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Network is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Network's management believes it is no longer subject to income tax examinations for years prior to 2011.

(2) Investments

Investments, short-term investments and statutory deposits comprise the following at December 31:

	<u>2014</u>	<u>2013</u>
Cash and cash equivalents	\$ 4,628,000	54,000
Certificates of deposit	1,955,000	1,912,000
Fixed income:		
U.S. agency obligations	322,000	335,000
Domestic corporate obligations	4,509,000	6,200,000
Municipal obligations	1,109,000	847,000
International corporate obligations	251,000	500,000
	<u>\$ 12,774,000</u>	<u>9,848,000</u>

Investment income and gains for investments comprise the following for the year ended December 31:

	<u>2014</u>	<u>2013</u>
Investment income:		
Interest and dividend income	\$ 352,000	188,000
Other changes in net assets:		
Change in net unrealized gains on investment	2,000	(29,000)

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

Gross unrealized losses and fair value, which have been in a continuous unrealized loss position at December 31, 2014:

	<u>Fair value</u>	<u>Cost basis</u>	<u>Unrealized losses</u>
Less than 12 months:			
Fixed income:			
Domestic corporate obligations	\$ 1,012,000	1,066,000	54,000
Municipal obligations	—	—	—
Total	<u>\$ 1,012,000</u>	<u>1,066,000</u>	<u>54,000</u>
12 months or longer:			
Fixed income:			
Domestic corporate obligations	\$ 998,000	1,024,000	26,000
Municipal obligations	227,000	229,000	2,000
International corporate obligations	322,000	344,000	22,000
Total	<u>\$ 1,547,000</u>	<u>1,597,000</u>	<u>50,000</u>

Gross unrealized losses and fair value, which have been in a continuous unrealized loss position at December 31, 2013:

	<u>Fair value</u>	<u>Cost basis</u>	<u>Unrealized losses</u>
Less than 12 months:			
Fixed income:			
Domestic corporate obligations	\$ 4,818,000	4,835,000	17,000
Municipal obligations	460,000	471,000	11,000
Total	<u>\$ 5,278,000</u>	<u>5,306,000</u>	<u>28,000</u>
12 months or longer:			
Fixed income:			
Domestic corporate obligations	\$ 249,000	250,000	1,000
Municipal obligations	385,000	387,000	2,000
International corporate obligations	248,000	249,000	1,000
Total	<u>\$ 882,000</u>	<u>886,000</u>	<u>4,000</u>

The unrealized losses were determined to be due to general market conditions and interest rates rather than a change in the credit quality of the issuer. The Network has no intent to sell these investments prior to recovery, and based on operating cash requirements, management believes the Network has the ability to retain these investments until recovery. As of December 31, 2014 and 2013, there were no investments deemed to be other-than-temporarily impaired.

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

(3) Reinsurance

The Network has a reinsurance policy with a third-party insurance company that provides reimbursement for certain costs of providing combined physician and hospital services to a member in excess of \$200,000. The amount of reimbursement is based on the lesser of the amount paid, contract amount, or per diem maximums. The maximum benefit the insurance company will reimburse the Network per member per year is \$2,000,000. The Network's reinsurer, Munich Reinsurance America, had an AM Best rating of A+ (superior) at December 31, 2014.

The Network had reinsurance premiums and recoveries of \$647,000 and \$816,000 in 2014, respectively, and \$788,000 and \$1,329,000 in 2013, respectively, and which are included in medical services in the statements of operations and changes in net assets.

(4) Commitments and Contingencies

Litigation

The Network is involved in litigation and regulatory matters arising in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Network's future financial position or results from operations.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as government healthcare program participation requirements, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs, together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Network is in compliance with the fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Operating Lease Commitments

The Network leases various office space and equipment from SHS under an operating lease. Total rental expense in 2014 and 2013 was \$230,000 and \$219,000, respectively. Future minimum lease payments under the office space operating lease are as follows for the years ending December 31:

2015	\$	<u>267,000</u>
	\$	<u><u>267,000</u></u>

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

(5) Related Parties

A significant portion of the Network's claim payments is made to the SHS Providers. SHS Providers were paid \$71,535,000 and \$45,452,000 for healthcare services during 2014 and 2013, respectively. These amounts are included in medical services expense in the statements of operations and changes in net assets.

SHS provides services to the Network for which the Network is charged. These services, which include salaries and benefits for certain employees who perform services on behalf of the Network, were \$8,943,000 and \$5,455,000 for the years ended December 31, 2014 and 2013, respectively.

The Network has purchased insurance for professional and general liability claims from Paradigm Indemnity Corporation, a Hawaii-domiciled captive insurance company and subsidiary of SHS, on a claims-made basis. The Network's premium expense under this insurance arrangement was \$76,000 and \$60,000 for the years ended December 31, 2014 and 2013 respectively.

(6) Regulatory Requirements

The Network files financial information with the State of Oregon using accounting principles that can differ from the accounting principles reflected in the financial statements. The filings with the State of Oregon do not allow certain assets to be recognized that are allowable under U.S. generally accepted accounting principles. As a result, the filing may reflect net assets different from those presented in the financial statements.

As a condition of operating as a risk contractor with the State of Oregon in the Medicaid program, the Network is subject to regulatory requirements that require the Network to establish and maintain a restricted reserve fund and a minimum level of net worth. The fair value of the statutory deposit representing the restricted reserve fund carried at December 31, 2014 and 2013 was \$5,824,000 and \$3,000,000, respectively, and primarily consists of domestic corporate obligations and money market funds.

As of December 31, 2014, the Network was in compliance with State requirements for minimum net worth, with a statutory net worth of \$23,033,029, compared to a required minimum of \$5,501,406. If the Network were to reach noncompliance with this requirement in a future period, it would implement a remediation plan in accordance with the operating agreement with the State of Oregon, which would include achieving earned excess of revenues over expenses, supplemented by contributions from SHS as necessary. In accordance with the operating agreement, these increases to the statutory net worth are to be made at a rate of 2% of the premium balance each quarter until compliance is achieved. If the Network falls out of compliance and management does not remediate in accordance with the operating agreement, the State of Oregon may impose additional sanctions against the Network, including reduction of the number of enrolled members.

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INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

December 31, 2014 and 2013

(7) Fair Value of Financial Instruments

The carrying amount reported in the balance sheets for maternity receivable, reinsurance receivable, other receivables, accounts payable, accounts payable to affiliates, and premium tax payable approximates fair value because of the short-term nature of these instruments.

Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Network has the ability to access.

Level 2 – Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used maximize the use of observable inputs and minimize the use of unobservable inputs.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Network believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

INTERCOMMUNITY HEALTH PLANS, INC.

Notes to Financial Statements

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The following table presents the balances of assets measured at fair value on a recurring basis at December 31, 2014:

	<u>Fair value</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Assets:				
Certificates of deposit	\$ 1,955,000	—	1,955,000	—
Fixed income:				
U.S. agency obligations	322,000	—	322,000	—
Domestic corporate obligations	4,509,000	—	4,509,000	—
Municipal obligations	1,109,000	—	1,109,000	—
International corporate obligations	251,000	—	251,000	—
	<u>\$ 8,146,000</u>	<u>—</u>	<u>8,146,000</u>	<u>—</u>

The following table presents the balances of assets measured at fair value on a recurring basis at December 31, 2013:

	<u>Fair value</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Assets:				
Certificates of deposit	\$ 1,912,000	—	1,912,000	—
Fixed income:				
U.S. agency obligations	335,000	—	335,000	—
Domestic corporate obligations	6,200,000	—	6,200,000	—
Municipal obligations	847,000	—	847,000	—
International corporate obligations	500,000	—	500,000	—
	<u>\$ 9,794,000</u>	<u>—</u>	<u>9,794,000</u>	<u>—</u>

(8) Subsequent Events

The Network evaluated subsequent events after the balance sheet date of December 31, 2014 through March 27, 2015, which was the date the financial statements were available to be issued.