Case No. _____

IN THE SUPREME COURT OF NEVADA

UNITE HERE HEALTH, a multi-employer health and welfare trust, as defined in ERISA Section 3(37); and NEVADA HEALTH SOLUTIONS, LLC, a Nevada limited liability company,

Petitioners,

vs.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, THE HONORABLE TARA CLARK NEWBERRY, DISTRICT COURT JUDGE,

Respondent,

- and -

STATE OF NEVADA EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER, NEVADA HEALTH CO-OP; and GREENBERG TRAURIG, LLP,

Real Parties in Interest.

District Court Case No. A-15-725244-C, Department XXI

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF VOLUME 3 OF 19

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February 25, 2021

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
VOLUME 3 OF 19

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TAB 13

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DISTRICT COURT
CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

v.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

CASE NO. A-17-760558-C
DEPT. NO. Department 18

COMPLAINT

Exempt from Arbitration:
Amount in excess of $50,000

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COMES NOW, Plaintiff, Barbara D. Richardson, Commissioner of Insurance in the State of Nevada, in her official capacity as Permanent Receiver of Nevada Health Co-Op ("Plaintiff" or "Commissioner"), with the Commissioner appointed in that official capacity on October 14, 2015 by the Eighth Judicial District Court, Clark County Nevada,[1] to serve as the permanent receiver ("Receiver") of the NEVADA HEALTH CO-OP ("NHC"), for the benefit of NHC's members, enrolled insureds, creditors, and the Receiver, by and through her attorneys, GREENBERG TRAURIG, LLP, and for her cause of action against Defendants MILLIMAN, INC. ("Milliman"), JONATHAN L. SHREVE ("Shreve"), and MARY VAN DER HEIJDE ("Heijde") (collectively the "Milliman Defendants"); MILLENNIUM CONSULTING SERVICES, LLC ("Millennium"); LARSON & COMPANY, P.C. ("Larson"), DENNIS T. LARSON ("D. Larson"), MARTHA HAYES ("Hayes") ("Larson," together with "D. Larson" and "Hayes," collectively the "Larson Defendants"); INSUREMONKEY, INC. ("InsureMonkey") and ALEX RIVLIN ("Rivlin," together with InsureMonkey, collectively the "InsureMonkey Defendants"); NEVADA HEALTH SOLUTIONS, LLC ("NHS"); PAMELA EGAN ("Egan"), BASIL C. DIBSIE ("Dibsie"), LINDA MATTOON ("Mattoon"), TOM ZUMTOBEL ("Zumtobel," together with Egan, Dibsie, and Mattoon, the "Officer Defendants"); BOBBETTE BOND ("Bond"), and KATHLEEN SILVER ("Silver," together with "Bond, the "Director Defendants") (the Officer Defendants and the Director Defendants collectively the "Management Defendants") (each a "Defendant," and collectively, all defendants are referred to as "Defendants") alleges as follows:

INTRODUCTION

1. Plaintiff, as Commissioner of the Nevada Division of Insurance (the "Nevada DOI") and NHC's Receiver, has brought this action on behalf of NHC, NHC's members, insured enrollees, and creditors.

2. NHC and its predecessors-in-interest were formed to provide health insurance to individuals and small businesses under the federal Affordable Care Act (the "ACA").

/ / /

[1] Commissioner Barbara D Richardson has succeeded Amy L. Parks, the former Commissioner of Insurance, who was initially appointed as Receiver by the Eight Judicial District Court.

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3. This complaint concerns certain providers of services to, and management of, NHC, and how their conduct, including their failure to perform applicable fiduciary, contractual, professional, and statutory standards, caused substantial losses to NHC and, ultimately, the other parties represented by the Commissioner.

4. InsureMonkey was contracted to provide software and related services, and to administer NHC's call center to enroll insureds, bill the insureds and the federal government for premiums, collect the premiums, confirm eligibility and, when necessary, terminate the coverage of insureds who failed to pay premiums due.

5. InsureMonkey failed on each account, causing losses to NHC. Additionally, without limitation, as some of InsureMonkey's compensation was paid based on the number of insureds it calculated, InsureMonkey was overpaid for its services due to its over reporting of the number of insureds. The faulty data provided by InsureMonkey also led to inaccurate reporting to regulatory authorities. Defendant Rivlin, InsureMonkey's Chief Executive Officer, mislead NHC concerning the capabilities and efforts of InsureMonkey to obtain lucrative contracts with NHC.

6. Milliman was NHC's consulting actuary, that, among other issues, produced deficient forecasts and studies for loan applications, set inadequate insurance premium levels, provided faulty actuarial guidance to NHC management, promoted and incorporated in its assumptions accounting entries that were neither proper nor authorized without appropriate disclosure, participated in financial misreporting, and improperly calculated and certified NHC's projections and reserves to regulators. Defendants Shreve and Heijde were individual actuaries of Milliman who certified actuarial data to the Nevada DOI in their individual names.

7. Millennium, an expert in statutory accounting and a consultant for insurance companies, was engaged by NHC to prepare and file NHC's financial statements and supplemental reports with the Nevada DOI and the National Association of Insurance Commissioners (the "NAIC"), assist in review and preparation of responses to insurance regulators and the NAIC regarding financials, respond to auditor inquiries, and provide statutory accounting and report support as needed. Millennium failed in its responsibilities, which included, without limitation, ensuring that statutory accounting and reporting principles had been followed, and its work resulted

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in financial misreporting to the Nevada DOI insurance regulators, and the prolongation of NHC's business at great loss beyond the point at which it would have been halted but for Defendant Millennium's acts and conduct.

8. Larson served as NHC's independent auditor that, among other issues, performed deficient audits, failed to adequately inspect and value reserves and receivables, failed to properly disclose related party transactions, and failed to disclose the existence of substantial doubts about NHC's inability to continue as a going concern. Defendants D. Larson and Hayes were the individual CPAs identified by contract as directly responsible for NHC's audits.

9. NHS is a company that was engaged by NHC to perform medical utilization management services. NHS failed in its position as a medical gatekeeper for NHC by among other concerns, failing to verify the eligibility of members for medical services during their utilization reviews, resulting in over $1 million in overpayments to medical services providers. In addition, NHS and Management Defendant Kathleen Silver engaged in self-dealing in which NHS and/or Kathleen Silver were unjustly paid substantial amounts by NHC for so-called utilization management and member eligibility review services. Upon information and belief, little work was provided under this utilization management arrangement by NHS for NHC, and NHS compensation was unfairly based on a mechanical fee of how many total members existed at NHC each month; a fee that bore little to no relation to services being provided by NHS. NHS's president was Management Defendant Kathleen Silver, and upon information and belief, the owner of NHS was Unite Here Health ("UHH"). Upon information and belief, UHH was an entity with financial ties and/or direct or indirect business links with Management Defendants Bobbette Bond, Thomas Zumtobel, and Kathleen Silver. UHH was being paid to process and adjudicate claims of NHC, and then it was being paid again through NHS to do a quality control review check of the very claims that UHH processed. NHS also had a conflict of interest, or the appearance of a conflict of interest, by being engaged to provide a quality control review of claim services provided by its parent company, UHH. The NHS and NHC medical utilization management review arrangement was unfair, unreasonable, and just another way to siphon more money out of NHC to the detriment of its members, policyholders, and creditors.

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10. This complaint also concerns the management of NHC who intentionally, fraudulently, in knowing violation of the law, and without reasonable belief that their actions were in the interests of NHC, directed, allowed, and/or concealed the internal control weaknesses of NHC, the wrongdoing of NHC's service providers, the squandering of funds to unjustly enrich themselves, the acts of self-dealing at the expense of NHC, the wrongful payment of claims and wrongful member enrollments, the loss of reinsurance recoveries, the continuation of NHC in business that led to substantial losses, and the misreporting of financial and operating results to regulators.

11. Each of the Defendants had a fundamental duty not to mislead government regulators and to perform their work in accordance with applicable fiduciary, statutory, professional, and contractual standards.

12. Defendants' acts and conduct concealed, for a time, NHC's approaching insolvency and its inability to continue as a going concern from regulators, and ultimately increased the losses suffered by NHC and the others represented by the Receiver.

13. Defendants' actions caused significant losses to NHC, its members, insured enrollees, and creditors, among others, until NHC ultimately failed, and the State of Nevada was forced to protect the public, seek appointment as a receiver, recoup losses caused by Defendants, and liquidate NHC's assets for the benefit of the public.

PARTIES

14. Plaintiff Commissioner Barbara D. Richardson, in her capacity as Commissioner of Insurance and as Permanent Receiver of Nevada Health Co-Op, is authorized to liquidate the business of NHC and to wind up its ceased operations pursuant to NRS 696B.220.2 and an order entered on October 14, 2015 by the Eighth Judicial District Court, Clark County, Nevada. This authority includes authorization to institute and to prosecute, in the name of NHC or in the Receiver's own name, any and all suits and other legal proceedings, and to prosecute any action that may exist on behalf of the members, insured enrollees, or creditors of NHC against any person. The Nevada DOI is and was at all relevant times a Department of the State of Nevada.

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15. NHC is and was at all relevant times a non-profit Nevada corporation.

16. Upon information and belief, Defendant Milliman is and was at all relevant times a Washington state corporation.

17. Upon information and belief, Defendant Shreve is and was at all relevant times a Consulting Actuary and Principal of Milliman residing in Denver, Colorado. He issued the Feasibility Study described later herein.

18. Upon information and belief, Defendant Heijde is and was at all relevant times a Consulting Actuary and Principal of Milliman residing in Denver, Colorado, and served as NHC's first "Appointed Actuary."

19. Upon information and belief, Defendant Millennium is and was at all relevant times a North Carolina limited liability company, with its principal place of business located in Raleigh, North Carolina.

20. Upon information and belief, Defendant Larson is and was at all relevant times a Utah professional corporation and Certified Public Accounting firm with its principal place of business located in Salt Lake City, Utah. Larson is registered to provide accounting services to Nevada entities with the Nevada State Board of Accountancy.

21. Upon information and belief, Defendant D. Larson is a CPA. He was the engagement partner who was responsible for supervising the 2013 audit of NHC. Upon information and belief, he is an individual residing in Utah. D. Larson is registered to provide accounting services to Nevada entities with the Nevada State Board of Accountancy.

22. Upon information and belief, Defendant Hayes is a CPA. She was the Larson engagement partner who was responsible for supervising the 2014 audit of NHC.

23. Upon information and belief, Defendant InsureMonkey is and was at all relevant times a Nevada corporation with its headquarters located in Clark County, Nevada.

24. Upon information and belief, Defendant Rivlin is and was at all relevant time an individual residing in Clark County, Nevada, and the Chief Executive Officer of InsureMonkey.

25. Upon information and belief, Defendant NHS is and was at all relevant times a Nevada limited liability company, with its headquarters located in Clark County, Nevada.

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26. Upon information and belief, Defendant Egan is and was at all relevant times an individual residing in Clark County, Nevada. Egan was NHC's Chief Development Officer from its inception through approximately April 2014. In or around April 2014, Egan became NHC's Chief Executive Officer, and she remained in that position through NHC's placement into receivership.

27. Upon information and belief, Defendant Dibsie is and was at all relevant times an individual residing in Clark County, Nevada. Dibsie was NHC's Chief Financial Officer from its inception through its placement into receivership.

28. Upon information and belief, Defendant Mattoon is and was at all relevant times an individual residing in Clark County, Nevada. Mattoon was NHC's Chief Operating Officer from approximately November 2014 through NHC's placement into receivership.

29. Upon information and belief, Defendant Zumtobel is and was at all relevant times an individual residing in Clark County, Nevada. Zumtobel was NHC's Chief Executive Officer from its inception through approximately April 2014. Zumtobel served on NHC's Board of Directors from May 4, 2012 through November 14, 2014. Zumtobel served on NHC's Budget and Audit and Consumer Advisory Committees.

30. Upon information and belief, Defendant Bond is and was at all relevant times an individual residing in Clark County, Nevada. Bond was a member of NHC's Board of Directors from May 4, 2012 through NHC's placement into receivership. Bond served on NHC's Budget and Audit and Consumer Advisory Committees.

31. Upon information and belief, Defendant Silver is and was at all relevant times an individual residing in Clark County, Nevada. Silver was a member of NHC's Board of Directors from May 4, 2012 through January 1, 2015, President of the Culinary Health Fund and President of Defendant NHS.

FACTUAL ALLEGATIONS

A. The Affordable Care Act

32. Congress enacted the Affordable Care Act (the "ACA") in March of 2010. The ACA included a series of interlocking reforms designed to expand coverage in the individual health insurance market.

33. The ACA bars insurers from taking a person's health into account when deciding whether to sell health insurance, generally requires each person to maintain insurance coverage or make a payment to the Internal Revenue Service, and gives tax credits to certain people to make insurance more affordable.

34. The ACA also established a Consumer Operated and Oriented Plan ("CO-OP") program which was intended to foster the creation of qualified non-profit health insurance issuers to facilitate the purchase of health plans by individuals and small businesses.

35. Under the CO-OP program, qualifying insurers were eligible for federal loans to establish and provide stability to insurers. Applicants were required to submit a feasibility study and a business plan as part of the loan application process.

36. Recognizing risks associated with the uncertainty of the reforms initiated by the ACA, Congress also established programs known as the "Federal Transitional Reinsurance," "Risk Corridors," and "Risk Adjustment" (known collectively as the "3Rs") to help mitigate some of the insurers' risks during their first few years of operation.

37. In addition to conforming to the ACA, health insurance providers, including those in Nevada, are required to adhere to state law and are regulated by state commissioners of insurance.

38. Without limitation, under Nevada law, NHC is required to have its reserves valued and certified by an actuary, file statutory financial statements, enroll members and pay claims according to guidelines, file independently audited financial statements, and submit other operational and financial data as determined by statute and by the Nevada DOI.

FACTUAL ALLEGATIONS RELATING TO THE MILLIMAN DEFENDANTS

B. Milliman is Engaged by and Establishes a Fiduciary Relationship with NHC and its Predecessors in Interest.

39. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

40. Recognizing the possible benefits to some of its members, the Culinary Health Fund (the health insurance affiliate of the Culinary Union), considered the possibility of establishing a qualifying CO-OP under the ACA.

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41. Due to the need to set insurance rates, establish appropriate reserves, apply for government loans, obtain required certifications, and forecast future results, the Culinary Health Fund sought out an actuarial expert.

42. The Culinary Health Fund entered into a contract with Milliman, dated October 20, 2011 (the "2011 Agreement").

43. Upon information and belief, the initial compensation for Milliman was contingent on the Culinary Health Fund obtaining federal loans for the CO-OP project.

44. Because the CO-OP program required separation from an established insurer, the Culinary Health Fund established Hospitality Health, Ltd., a Delaware non-profit corporation ("Hospitality Health").

45. On information and belief, the Culinary Health Fund assigned and transferred all rights, title, and interest in the 2011 Agreement to Hospitality Health.

46. Milliman continued to perform work under the 2011 Agreement for Hospitality Health after the assignment.

47. On or about September 10, 2012, Milliman also directly entered into a Consulting Services Agreement (the "Consulting Services Agreement") with Hospitality Health.

48. The Consulting Services Agreement provides that "Milliman will perform all services in accordance with applicable professional standards."

49. NHC was formed in October, 2012, and all assets and agreements of Hospitality Health, including the Consulting Services Agreement, were assigned to NHC.

50. Milliman holds itself and its employees out as experts in providing actuarial opinions and other services to third parties.

51. Milliman represented itself to the Culinary Health Fund, Hospitality Health, and NHC, as much more than a simple service provider.

52. In its proposal dated April 12, 2012, Milliman described the CO-OP development as "an interactive partnership in order to ensure the viability of the CO-OP in a short timeframe."

53. As an "interactive partnership," Milliman proclaimed joint responsibility for the success of the CO-OP.

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54. Furthermore, Milliman committed that its work would be done in a manner "to ensure the viability of the CO-OP."

55. The proposal further boasted that Milliman could provide "significant assistance" to the CO-OP in areas of standard actuarial tasks within an insurer, as well as development, strategy, and training.

56. Milliman, by framing itself as an interactive partner with Hospitality Health and its successor, NHC, in developing strategy, and in training its staff, Milliman did not perform a mere set of outsourced tasks, but rather served as the key partner providing budget forecasts, planning, premium pricing, opinions, and judgments that were justifiably relied on by the new CO-OP.

57. As newly formed non-profit companies, Hospitality Health, and later NHC, relied on the superior knowledge and expertise of its self-proclaimed "interactive partner" Milliman and Milliman's actuaries - Shreve and Heijde - to establish and run the enterprise.

58. In its position as an "interactive partner," the Milliman Defendants enjoyed a special relationship and position of trust with the Culinary Health Fund, Hospitality Health, and NHC.

59. Services ultimately to be provided by the Milliman Defendants included preparing a feasibility study to be included in loan applications and statutory filings, projecting future profits, valuing reserves, setting premiums, participation in financial reporting, and serving as the CO-OP's statutorily required appointed actuary to provide certifications to the state and other entities.

C. Milliman Provides a Defective Feasibility Study, $66 Million in Federal Loans are Obtained, and Hospitality Health's Assets and Loans are Assigned to and Assumed by NHC.

60. On or about December 21, 2011, Milliman issued a document entitled "Hospitality Health Feasibility Study and Business Support for Consumer Operated and Oriented Plan (CO-OP) Application" (the "Feasibility Study"), which was to be used for the application for federal loans under the CO-OP program and for other purposes.

61. The Feasibility Study included financial projections of what Milliman labeled as its "Best Estimate Scenario" and "Alternative Scenarios." Milliman also included an analysis of the CO-OP's ability to repay loans applied for under the application.

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62. The results of Milliman's analysis concluded that regardless of each scenario it tested, the CO-OP would:

- Achieve sufficient market penetration to support its expenses;
- Meet statutory minimum loss ratio requirements;
- Maintain a surplus level in excess of the minimum required to avoid Nevada DOI oversight; and
- Generate enough surplus to repay its federal loans.

63. In fact, Milliman projected that under its "Best Estimate Scenario," the CO-OP would generate an accumulated surplus in excess of $27 million by the end of 2014, $64 million by the end of 2017, and $144 million by the end of 2033.

64. Indeed, under each and every scenario presented in its report, Milliman stated that the CO-OP would generate a positive accumulated surplus.

65. Based at least in part on the Milliman projections, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") and Hospitality Health, entered into a loan agreement with a closing date of May 17, 2012 (the "CMS Loan Agreement").

66. The CMS Loan Agreement provided for a total of $65,925,394 in loans, including a Series A Start-up Loan with a maximum amount of $17,105,047 (the "Start-up Loan"), and a Series B Solvency Loan in the maximum amount of $48,820,347 (the "Solvency Loan," collectively, the "CMS Loans").

67. On or about December 21, 2012, by a Joint Resolution of the Boards of Directors of Hospitality Health and of NHC, the assets and liabilities of Hospitality Health, including the CMS Loans and the Consulting Services Agreement with Milliman, were assigned to and assumed by NHC.

68. During the transaction, the Boards of Directors of Hospitality Health and of NHC were identical and included many of the Management Defendants.

69. On December 21, 2012, CMS amended the CMS Loan Agreement to substitute NHC for Hospitality Health.

70. NHC was funded by the CMS Loans. Without the CMS Loans, NHC would not have had sufficient funds to qualify for licensing or to begin selling insurance.

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71. Based on the conclusions of the Feasibility Study and on the availability of the CMS Loans obtained through its use, in 2013 the Nevada DOI licensed NHC to begin selling insurance as of January 1, 2014.

D. Milliman's Work Does Not Meet Applicable Professional and Statutory Standards.

72. Throughout its relationships with the Culinary Health Fund, Hospitality Health, and NHC, the Milliman Defendants' work failed to meet applicable professional and statutory standards.

73. Without limitation, these deficiencies manifested themselves in the work Milliman performed relating to premium rate development, financial projections and reserve calculations, and financial misreporting. Moreover, Milliman improperly utilized financial information that it knew to be incorrect and that had not been adequately disclosed.

1. Premium Rate Development.

74. Premium rate development is a critical process for the viability of an insurer. If rates are set too low, the insurer cannot pay the medical and administrative costs, and the company will eventually fail. Conversely, if rates are set too high, the insurer will not achieve the necessary or desired market share because its products will be more expensive than those of its competitors. As a result, revenue will be inadequate.

75. As a start-up company, NHC relied heavily on its expert, actuary, and "interactive partner" Milliman, to identify appropriate assumptions and to perform the necessary actuarial calculations to establish NHC's premiums at a level that could support NHC's continued existence.

76. When developing premium rates, actuaries must comply with applicable statutory and professional standards, including those published by the NAIC and the Actuarial Standards of Practice ("ASOPs") of the U.S. Actuarial Standards Board. Such standards require the use of appropriate assumptions when developing premium rates.

77. The Milliman Defendants intentionally or negligently failed to comply with such standards.

78. In the development of NHC's 2014 and 2015 premium rates, the Milliman Defendants made a series of unjustified and inappropriate assumptions that adversely impacted NHC's premium rates.

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79. The use of these unjustified and inappropriate assumptions ultimately impacted NHC's financial viability, as mispriced premiums were unable to cover actual expenses and costs.

80. Inappropriate assumptions used by the Milliman Defendants in the premium development process that NHC ultimately relied on for its financial viability included, but were not necessarily limited to:

i. Milliman's estimates of premium rates were based on Milliman's Health Cost Guidelines (HCGs). The HCGs are based on data collected from large-group, employer-based health plans, a population with characteristics that are inherently different from those present in the individual and small-group market. As such, Milliman knew or should have known that the claim costs it projected based on data underlying the HCGs were not appropriate for the individual and small group customers that plans under the Affordable Care Act were designed to serve, unless substantial adjustments were made. Milliman failed to make such appropriate adjustments.

ii. Contrary to the ASOPs applicable to its work, Milliman did not adequately account for adverse selection - the concept that those with the greatest need and likely to generate the highest cost would be the most likely to seek apply for their most beneficial plans. Adverse selection was a critical, material, obvious, and foreseeable consideration from an actuarial perspective. The upper tier plans proved so unprofitable that all Platinum and most Gold plans were cancelled in NHC's second year of operations.

iii. Inflation adjustments used by Milliman were too low, based on commonly known data and Milliman's own firm views. Had Milliman appropriately applied a higher inflation factor, premiums would have been higher, reducing NHC's financial losses.

iv. Milliman underestimated pent-up demand for medical insurance at a lower price point. The ACA subsidized lower income insureds. Once funded, individuals with conditions that had remained untreated were suddenly able to receive the health care they needed, and understandably and predictably, these individuals tended to make use of medical services en masse.

v. Milliman's projections, even in its "low enrollment" scenario did not sufficiently consider the adverse effects of low enrollment or slow enrollment. As a result, the provision for administrative expenses in Milliman's pricing analysis that the NHC relied upon was

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also deficient. The anticipated administrative expenses of NHC were spread over a smaller enrollment population than Milliman had projected, leading to a greater loss on each insured.

vi. Milliman failed to account for the high administrative costs necessary for a startup company, such as NHC. Despite the fact that the Feasibility Study showed administrative cost of $6.8 million in 2014 for far fewer enrollees, actual 2014 expenses were $23.6 million, flagging the disastrous financial impact of improper budgeting based on Milliman's faulty projections.

vii. Finally, proper consideration of NHC's target market was essential to estimating appropriate premiums and understanding potential risks. Milliman intentionally or negligently failed to assess NHC's target market by attempting to position NHC as the low-cost provider and in effect, "buy" participation.

81. While Milliman was aware of the challenges in the market, Milliman intentionally or negligently failed to adequately explain to NHC or to its regulators the inherent risks and uncertainty in the underlying rate development, the interaction of coverage levels in product offerings, and the dangers of competitive positioning as the low-cost provider in the market. This failure contributed significantly to the mispricing of premiums, and ultimately, the demise of NHC.

2. Financial Projections.

82. In developing NHC's financial projections, such as the Feasibility Study and other pro formas or financial reports, Milliman and Shreve made a series of inappropriate and unjustified assumptions that caused the financial projections they presented to management, the Nevada DOI, and CMS to be unrealistic and unachievable in practice.

83. When preparing financial projections such as those prepared by Milliman, an actuary's work is subject to professional and statutory standards, including those published by the NAIC, and the American Academy of Actuaries, including but not limited to ASOP No. 7 – "Analysis of Life, Health, or Property-Casualty Insurer Cash Flows," among other professional guidance.

84. The Feasibility Study included a certification by Milliman Consulting Actuary and Principal, Shreve, that stated, in part, that the projections were prepared under his supervision, were "accurate and complete," and were "prepared in accordance with generally recognized and accepted

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principles and practices which are consistent with Actuarial Standards of Practice, the Code of Professional Conduct and Qualification Standards for Public Statements of Actuarial Opinion of the American Academy of Actuaries."

85. The inappropriate and unrealistic assumptions used by Milliman in its financial projections include, but are not limited to, those set forth in the Premium Rate Development section above.

86. The use of such inappropriate and unjustified assumptions violated applicable statutory and actuarial standards.

87. In the feasibility study dated December 21, 2011, prepared by Milliman and used in support of the loan application to CMS, Milliman concluded, "Our financial projections indicate [the CO-OP] will be able to repay its startup loans within five years of their specific drawdown dates. Further, we project [the CO-OP] will have sufficient capital to repay its solvency loans within fifteen years of their specific drawdown dates while meeting state reserve requirements and solvency regulations. These projections are based on best estimate assumptions but also hold true for the alternate scenarios tested."

88. None of the enrollment scenarios considered the possibility that NHC would have trouble attracting an adequate level of enrollment, and every economic scenario assumed that the loss ratio in nearly every modeled year would contribute to a surplus. These assumptions completely disregarded the obvious possibility that there would be significant volatility in enrollment and/or the medical loss ratio. In fact, for example, NHC's medical payments in 2014 alone exceeded the premiums received, even before administrative costs.

89. With all of the uncertainty surrounding implementation of the ACA, a competent actuary should have understood that it was a very realistic possibility that NHC would fail to be viable. Some of the modeled scenarios should have identified this possibility so as to inform NHC management and regulators. Possible scenarios, such as low enrollment, very high medical costs, and high administration expense, were not presented in the Feasibility Study, while in actuality, these possibilities should have been anticipated by Milliman actuaries when they prepared the Feasibility Study.

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90. Milliman's intentional or negligent failure to consider the possibility of these adverse enrollment and/or medical loss ratio scenarios resulted in every single scenario of the Feasibility Study showing that NHC would generate significant positive cash flows over the mid to long-term time period.

91. Milliman had a financial incentive to paint such a rosy outlook, even if it was in contradiction to actuarial standards. Upon information and belief, Milliman conditioned payment for its preparation of NHC's Feasibility Study upon NHC being awarded a loan by CMS. That is, Milliman would only receive payment for its services if NHC's efforts to secure a loan from CMS were successful.

92. By conditioning payment upon a successful result, Milliman compromised its independence as an actuary and thereby breached its duty to NHC.

93. As the certifying actuary for the Feasibility Study, Shreve is jointly and severally responsible with Milliman, his employer, for the work performed on the Feasibility Study.

94. Milliman failed to include and properly calculate actuarial reserves when preparing liability information that would later be relied upon and used by NHC in its financial reporting to Nevada DOI insurance regulators for year 2014 and the first calendar quarter of year 2015. Milliman would also certify to these improper actuarial reserves in separate reports submitted to the Nevada DOI regulators.

3. Reporting of Reserves.

95. Milliman and Heijde intentionally or negligently underreported actuarial items used in NHC's financial reports and which were submitted to the Nevada DOI. The under accrual of the December 31, 2014 reserves, including but not limited to premium deficiency reserves ("PDR") and incurred but not reported ("IBNR") reserves, caused NHC to appear financially stronger and solvent. On information and belief, they also intentionally or negligently used sources containing improper financial information that tended to artificially maintain surplus levels reported to the Nevada DOI without proper authorization or adequate disclosure.

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96. The understated PDR and IBNR reserves overstated the surplus levels and risk based capital ("RBC") ratios that the Nevada DOI used to assess the solvency of insurers. An insufficient RBC ratio would have been a red flag to the Nevada DOI and would have required NHC to take corrective steps, limiting acceptability to consumers, creditors, and regulators.

97. NHC management and the Milliman Defendants understood that the higher the IBNR reserves and PDR were, the lower the surplus and the worse the RBC ratio would be. Keeping the IBNR reserves and PDR artificially low and the surplus high masked NHC's insolvency and allowed NHC to continue to take on risk and lose money.

98. When developing and certifying reserves, actuaries must comply with statutory and professional requirements and standards.

99. NRS 681B requires, in part, that the opinions of an "appointed actuary" as to whether the reserves and related actuarial items held in support of the policies and contracts of an insurer are computed appropriately, be based on conditions that satisfy contractual provisions, be consistent with prior reported amounts, and comply with applicable laws of the State of Nevada.

100. NRS 681B also provides minimum statutory requirements for actuarial opinions on reserves, including compliance with the Valuation Manual adopted by the NAIC.

101. Actuaries are also required to comply with relevant standards set forth by the American Academy of Actuaries and the Actuarial Standards Board when setting reserves, including but not limited to ASOP 42 – "Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims" and ASOP 5 – "Incurred Health and Disability Claims."

102. For the typical health entity offering comprehensive medical insurance coverage, the size of the PDR reported in a company's annual financial statement should be consistent with the expected underwriting loss for the following year.

103. On March 13, 2015, and subsequently on May 14, 2015, Heijde and Milliman issued their Actuarial Memorandum and Statement of Opinion for the NHC (the "2014 Opinion"). In the 2014 Opinion, Heijde described that their role was to "certify that all required reserves have been established, at good and sufficient levels."

104. For the 2014 Opinion, Heijde and Milliman calculated a PDR of $0 for NHC.

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105. The PDR calculation produced a positive value of $197,162, where a negative number implies a reserve is to be held.

106. This calculation was not credible or in accordance with professional or statutory standards, as evidenced by the substantial prior and continuing losses of NHC.

107. Heijde and Milliman also grossly underestimated NHC's year-end 2014 IBNR reserves, overstating NHC's surplus position.

108. That calculation, based on known facts concerning unprocessed claims, was inconsistent with statutory and professional standards.

109. Heijde served as the appointed actuary for NHC and personally executed the 2014 Opinion.

110. The 2014 Opinion contained the opinion of Heijde and Milliman that the amounts carried on NHC's balance sheet on account of inadequately disclosed information were in accordance with accepted actuarial standards, that they were based on relevant and appropriate actuarial assumptions, that they met the requirements of the insurance laws and regulations of the State of Nevada, and that they were at least as great as the minimum amounts required to make full and sufficient provision for all unpaid claims and other actuarial liabilities of the organization.

111. The 2014 Opinion stated that Heijde's review indicated that the parties were in a financial position to meet all liabilities resulting from its relevant contracts, that she performed calculations to determine the need for a PDR, and that she determined that such a PDR was not necessary.

112. The 2014 Opinion confirmed that it was prepared for NHC's filings with the State of Nevada, NHC's auditors, the NAIC, CMS, and the Nevada DOI.

113. The 2014 Opinion raised concerns with the Nevada DOI when it noticed the apparent discrepancies between the report filed by Heijde and the actual results of NHC. It held telephonic conferences and issued written correspondence in an effort to investigate the issue.

114. On February 10, 2015, the Nevada DOI held a call to discuss the estimation of actuarial items relating to the financial statements with the Milliman team. In an e-mail dated February 14, 2015, at 8:00 p.m. on a Saturday, the Nevada DOI sent extensive and specific

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recommendations to Milliman and NHC on the methodology to calculate the year-end PDR. The Nevada DOI expressed concerns about unrealistic expense levels and the importance of projecting PDR through the end of 2015 using reasonable and supportable assumptions.

115. The Nevada DOI included an excerpt of the then-current draft of applicable guidance to address the calculation and communication of the PDR, and it highlighted in bold italics detailed notes specific to NHC. In particular, the DOI questioned NHC's financial position and its elevated combined ratio stating, specifically:

> "In particular, based on the high level of expenses, and the level of underwriting losses projected for 2015, along with the premium increase limitations built into the ACA, we do not believe that it is reasonable for NHC's PDR to reflect a projection to the end of the contract period. In other words, without providing significant evidence to support the adequacy of renewal premiums, NHC should be projecting all groups through the end of the projection period (to 12/31/2015) using reasonable and supportable projection assumptions."

116. Milliman's calculated PDR of zero is even more alarming, given the detailed instructions provided to Milliman by the Nevada DOI in an e-mail from Annette James to Colleen Norris, dated February 14, 2015:

> "The size of the PDR reported in a company's annual financial statement should be consistent with the expected underwriting loss for the following year."

117. A week later, on February 18, 2015, the Nevada DOI followed up with a conference call with Milliman regarding the calculation of actuarial items. In a February 26, 2015 e-mail from Annette James to Basil Dibsie, the DOI stated the following:

> "***We are concerned that the preliminary December 31, 2014 premium deficiency reserve (PDR) of zero which was discussed during that call appears to be understated***. While the projected premiums and claims appear to be in line with our expectation, the level of projected expenses, combined with the expected risk corridor receipts appear to be optimistic, resulting in a PDR that appears to be understated. From a big picture perspective, it appears to be optimistic for the CO-OP to go from $21 million deficit as of 12/31/14 to a surplus position within a year. ***We therefore urge you and your actuaries to review the estimates and ensure that the appropriate level of conservatism is incorporated into the year-end estimates.*** Once the requested spreadsheets and back-up information are provided to us, we will review the calculations and may be in a position to provide specific feedback at that time." ***[emphasis added]***

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118. The Nevada DOI went to extraordinary lengths to communicate clear guidelines for the calculation of PDR so as to produce "fairly stated year-end financials with information that is consistently applied." The then acting Insurance Commissioner made herself available for multiple calls and initiated and responded to numerous e-mails, including during non-traditional business hours. Despite the Nevada DOI's clear instructions, Milliman, Heijde, and certain members of NHC management, including but not limited to Egan and Dibsie conspired to conceal the true financial position of NHC and refused to follow the Nevada DOI's guidance.

119. In addition, in its e-mails dated February 14, 2015 and February 26, 2015, the Nevada DOI stated it expected the PDR to be reevaluated on a quarterly basis and adjusted as necessary if the emerging experience was substantially different from the projected experience. These steps were not taken and, in fact, the PDR calculation appears to have been skipped at the end of the first quarter, contrary to the Nevada DOI's explicit request.

120. By July 31, 2015, Milliman issued a document titled "Premium Deficiency Reserve as of June 30, 2015." This time, Milliman calculated that NHC would be required to hold a significant PDR.

121. The July 31 PDR calculation produced a value of ($15,928,707), where a negative number implies a reserve to be held, a roughly $16,000,000 swing from the March 14 calculation.

122. On December 31, 2014, Milliman had first calculated an IBNR reserve of $5.8 million, but then in May restated that number to be $11.0 million. By June 30, 2015, Milliman calculated the balance as $15,027,286, while still not establishing a PDR. This was a significant and unfavorable swing in NHC's financial position from year-end.

123. Still, Milliman did not restate the 2014 financial statement information. The continuing avalanche of negative claims should have provided ample reason to revisit the 2014 reserves, but Milliman failed to do so.

124. In total, the reported reserves shifted tens of millions of dollars in a few short months.

125. As the certifying actuary for the 2014 Opinion, actuarial memorandum, and subsequent communications with the Nevada DOI, Heijde is jointly and severally responsible with her employer, Milliman, for the work performed for the 2014 Opinion, actuarial memorandum, and NHC's reserve calculations.

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4. Use of Improper and Unauthorized Financial Information.

126. In addition to the understatement of reserves, on information and belief, Milliman, Heijde, and NHC management intentionally or negligently used financial information, recording loan proceeds as a receivable in the year prior to that in which a formal application for the draw was made, and participated in misreporting 2014 financial information to the Nevada DOI without adequate and proper disclosures of operating results and NHC's viability. Milliman, Heijde, and NHC management knew or should have known that these practices would tend to artificially maintain surplus levels, avoid the level that would trigger Nevada DOI supervision, misreport financials, and extend the continued and unjustified existence of NHC as an operating insurance business enabling it to write more insurance risks and undertake more financial obligations.

127. The practice of prematurely booking potential CMS loan draws as receivables without adequate disclosure was used to bolster risk-based capital levels to help meet statutory requirements.

128. The outstanding balance on the Solvency Loan as of December 31, 2014, was $42,965,683. The maximum principal available under the loan was $48,820,349. Although a draw in the amount of $3,152,275 was formally requested in January 2015 and obtained in February 2015, the transaction was recorded as if it had occurred as of December 2014, which Milliman knew was inaccurate and misleading without additional disclosure.

129. Milliman set IBNR reserves too low and no PDR reserves until July 31, 2015, in violation of actuarial standards and practices and without due regard to NHC's operating results and information, which was inaccurate and misleading.

130. Given the other issues noted above, had the CMS loan final draw been correctly recorded in 2015, it would have negatively impacted the critical ratio testing requirement with the Nevada DOI.

131. The clear pattern of reduced and understated actuarial items on the balance sheet for IBNR reserves and PDR, along with the use of inappropriate and inadequately disclosed financial information to meet statutory requirements, indicates that Milliman's estimates were arrived at in an effort to falsely inflate NHC's surplus levels and RBC ratio position, as well as to misreport the 2014 financial information of the company, so as to avoid or postpone inevitable Nevada DOI intervention.

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FACTUAL ALLEGATIONS RELATING TO MILLENNIUM

E. Millennium Represents Itself as an Accounting and Consulting Firm with Insurance Industry Expertise and is Engaged by NHC to Prepare and File Statutory Statements.

132. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

133. Financial reporting for insurance companies is complex and involves issues not frequently encountered by those in other industries.

134. NHC was required to file statutory basis financial statements and compliance reports related to the audit of federal awards.

135. The Nevada DOI recognizes only statutory accounting practices prescribed or permitted by the State of Nevada. The NAIC's Accounting Practices and Procedures Manual ("SAP") has been adopted as a component of prescribed or permitted practices by the State of Nevada.

136. On information and belief, during late 2014, NHC sought out an accounting firm that was an expert in insurance accounting, reporting, and consulting.

137. Millennium reports on its website that it provides educational training, regulatory consulting, and administrative services to insurance companies, insurance regulators, and other insurance-related entities throughout the United States and Puerto Rico.

138. Millennium's website also states that "Millennium Consulting's portfolio of services provides a variety of solutions to meet the demanding obligations of statutory accounting and reporting regulations."

139. On information and belief, NHC identified and engaged Millennium after NHC's employee attended a statutory accounting seminar put on by Millennium and because of Millennium's self-proclaimed expertise in statutory accounting and reporting regulations for the insurance industry.

140. On or about January 7, 2015, NHC entered into a service agreement (the "Service Agreement") with Millennium to provide accounting and consulting services. Under the terms of the Service Agreement, Millennium was to:

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- Prepare and file NHC's Annual Statement, including all NAIC Supplemental Exhibits and Schedules for filing with the Nevada DOI and the NAIC;
- Prepare and file NHC's Quarterly Statement, including all NAIC Supplemental Exhibits and Schedules for filing with the Nevada DOI and the NAIC;
- Assist in the review and prepare responses to any regulatory letter from the Nevada DOI and the NAIC related to the Annual and/or Quarterly Statement filings;
- Respond to any independent auditor inquiries regarding the preparation and filing of NHC's Audited Statement Supplemental filings, as needed; and
- Acquire, on behalf of NHC, Annual and Quarterly RBC software.

141. Schedule A to the Millennium Service Agreement specified that the contracted work would include preparation of schedules "in accordance with statutory accounting and reporting rules prescribed and permitted by the State of Nevada" and "entail evaluating general ledger accounting entries, ensuring that statutory accounting and reporting principles have been followed, recommending any adjustments to adhere to statutory accounting and reporting rules prescribed by the state of [Nevada] and preparing any supporting worksheets that may be needed in arriving at appropriate allocations of financial amounts within some of the schedules."

142. By undertaking the contractual duties specified in the Service Agreement, Millennium agreed to perform the duties of an internal financial controller. In this position, NHC relied on the superior knowledge and expertise that Millennium touted to run NHC. In this position, Millennium enjoyed a special relationship and position of trust with NHC.

F. Millennium Fails to Live Up to its Contractual Obligations to Prepare Financial Statements in Accordance with Applicable Standards.

143. Despite the fact that Millennium was to evaluate general ledger entries, to ensure that statutory accounting and reporting principles had been followed, and to recommend any adjustments so as to adhere to statutory accounting and reporting rules prescribed by the State of Nevada, the reports prepared and filed by Millennium under the Service Agreement failed to meet applicable statutory, professional, and contractual standards.

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144. NHC's 2014 Annual Statement (the "2014 Annual Statement") was not prepared in accordance with statutory accounting and reporting rules, and it had to be subsequently amended.

145. Millennium did not properly disclose the reliance on extraordinary state prescribed or permitted practices, whether such prescribed or permitted practices were approved, or whether the reporting entity's risk based capital ratios would have triggered a regulatory event had it not used a prescribed or permitted practice.

146. Inappropriate and unapproved wording was used in the notes to the 2014 Annual Statement.

147. Data presented between schedules was inconsistent.

148. The 2014 Annual Statement disclosure regarding the CMS Loans was not in conformity with applicable standards, including SSAP 15, because there was no disclosure regarding the covenants associated with these loans.

149. The 2014 Annual Statement did not disclose material related party transactions.

150. The 2014 Annual Statement did not disclose significant internal control weaknesses that materially impacted operations and the financial statement.

151. The 2014 Annual Statement reflected without adequate disclosure, a receivable amount of $3.2 million as of December 31, 2014, with an offsetting entry to surplus in the form of the CMS Solvency Loan, despite the fact that NHC did not submit a formal loan request to CMS until the subsequent year.

152. NHC incurred significant losses for the year ending December 31, 2014 that exceeded the financial projections included in its CMS application and in NHC's licensing application with the Nevada DOI. Additionally, enrollments were substantially below target, and cash flow was a problem, with credit lines becoming rapidly exhausted.

153. Millennium failed to adequately disclose required reserves, projected future losses for 2015, the impact on NHC's RBC results, the impact on NHC's CMS loan covenant requirements, projected future shortfalls in enrollments, the exhaustion of NHC's available lines of credit, the growing concern regarding NHC's ability to continue as a going concern, and NHC's plan to mitigate these negative trends.

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154. For the first quarter of 2015, many of these issues, including without limitation the understatement of reserves, remained unaddressed, and the first quarter 2015 statutory statements prepared and filed by Millennium were not in conformance with required contractual, statutory, or professional standards.

155. Millennium further participated in the drafting of NHC's Management's Discussion & Analysis (the "MD&A") report for 2014 as required under the Service Agreement.

156. Nevada has adopted NAIC reporting rules by statute and order of the Nevada DOI. Pursuant to NAIC rules, the MD&A requirements are intended to provide, in one section, material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity. Under NAIC rules, reporting entities should identify any known trends or any known demands, commitments, events or uncertainties that will result in or that are reasonably likely to result in the reporting entities' liquidity increasing or decreasing in any material way.

157. The 2014 MD&A prepared by Millennium did not explain or discuss the severity of NHC's financial position nor did it provide the MD&A's users with relevant and required information regarding extraordinary accounting practices in use, the inadequacy of reserves, liquidity and borrowing concerns, or other challenges faced by NHC. As such, Millennium failed to perform its work in accordance with the NAIC rules prescribed and permitted by the State of Nevada, as required by the Service Agreement.

FACTUAL ALLEGATIONS RELATING TO THE LARSON DEFENDANTS

G. Larson Represents Itself as a CPA Firm with Insurance Industry Expertise and is Engaged by NHC to Audit the Company.

158. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

159. The audits of insurance companies may be complex and involve issues not frequently encountered by companies not specializing in such audits.

160. On information and belief, during late 2013 and early 2014, NHC sought out a CPA firm that was an expert in auditing and advising insurance companies.

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161. Larson is a Certified Public Accounting firm that asserts in its website that it "began practice in 1975 with the central purpose of serving the insurance industry. We have grown to become one of the premier insurance audit firms in the nation . . ."

162. Its website continues by saying that, "while many insurance companies prepare GAAP [Generally Accepted Accounting Practices] statements for internal use, statutory filings are required by all licensed insurance companies. These regulations are very different from GAAP regulations. Because of this, only individual with industry specific expertise can fully comprehend the impact of different transactions. And without this understanding, it is difficult for an insurance company to operate successfully long term. . . . When choosing professional advisors to help you navigate the rapidly shifting waters of the insurance industry, you need experienced, knowledgeable professionals. Our insurance group is an integrated team of audit, tax, and advisory professionals delivering sophisticated business solutions to help our clients minimize their growth potential and remain competitive."

163. On information and belief, NHC identified and engaged Larson because of its self-proclaimed expertise in insurance company audits.

164. On or about February 19, 2014, NHC and Larson entered into an engagement letter under which Larson would provide professional services to NHC.

165. The February 19, 2014 engagement letter drafted by Larson included the following statements:

- "We will audit the statutory financial statements of Nevada Health Co-Op (the Company) which comprise the statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2013, and the related statutory statements of income, changes in capital and surplus, and cash flows for the year then ended. Also the following supplementary information accompanying the statutory financial statements will be subjected to the auditing procedures . . . . :
  - The National Association of Insurance Commissioners' (NIAC) required supplementary information
  - Schedule of Expenditures of Federal Awards

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- The objective of our audit is the expression of opinions as to whether your statutory financial statements are fairly presented, in all material respects, in conformity with statutory accounting principles and to report on the fairness of the supplementary information referred to in the [above] paragraph.

- Our audit will be conducted in accordance with the auditing standards generally accepted in the United States of America; the standards for financial audits contained in Government Auditing Standard, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the provisions of OMB Circular A-133, and will include test of accounting records, a determination of major programs(s) in accordance with OMB Circular A-133, and other procedures we consider necessary to enable us to express such opinions and to render the required reports.

- Dennis T. Larson, CPA, is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it."

166. A subsequent engagement letter with similar terms, dated September 30, 2014 (collectively, with the February 19, 2014 engagement letter, "Engagement Letters"), was also entered into by NHC and Larson for the year ended on December 31, 2014, with Martha Hayes as the responsible CPA.

H. Larson Defendants Ignore Glaring Warning Signs, Perform Only a Cursory Review of Material Items, and Issue Opinions on NHC's 2013 and 2014 Financial Statements without Adequate Justification, Disclosure, or Qualifications.

167. During 2014 and into 2015, the Larson Defendants performed an audit on the books and records of NHC and completed other work concerning supplemental information to be presented regarding NHC.

168. In early 2015, NHC and its actuary, Milliman, filed preliminary financial reports with the Nevada DOI for the year ended December 31, 2014.

169. These reports included analysis of NHC's actuarial reserves.

170. These reports showed no PDR and only $5.8 million in IBNR reserves as of December 31, 2014.

171. NHC's reserve levels raised concerns.

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172. As set forth above, throughout early 2015, the Nevada DOI went to extraordinary lengths to communicate clear guidance for the proper calculation of reserves.

173. Given the guidance delivered by the Nevada DOI and additional guidance given by the NAIC, the balances of the reserves should have been questioned and audited both from a year-end perspective and as part of Larson's subsequent event testing. Yet there is no evidence in the audit work papers that anything more than a cursory review took place.

174. Even without adjusting reserve balances, NHC had reported losses of over $8 million in 2013 and over $16 million in 2014.

175. Up until Larson issued its reports on June 1, 2015, NHC continued to hemorrhage losses.

176. NHC had all but exhausted its remaining capital by that time.

177. NHC exhausted what remained of its almost $66 million in CMS Loans in early 2015, and had no borrowing capacity remaining, given its huge losses.

178. These should all have been "red flags" to the Larson Defendants that NHC would be unable to continue as a going concern.

179. Alarmingly, a receivable related to a CMS loan request was recorded in 2014, although it was not even formally applied for in that year, but rather in the following year. Adequate disclosure of this transaction was not included in the 2014 audited financial statements.

180. As auditors specializing in insurance companies, Larson knew or should have known that recording of a receivable concerning proceeds of the loan in the year before it was formally applied for, without adequate authorization or disclosure, was misleading, could artificially inflate NHC's reported surplus levels, and could make NHC appear more solvent than it actually was.

181. NHC's officers and directors were relatively inexperienced in insurance matters and were unable to establish sufficient internal controls over its business.

182. NHC also relied on outside service providers to perform critical processes for NHC, creating another set of internal control concerns.

183. Contractors handling enrollment, claims processing, billing, receipt of premiums, premium rate setting, actuarial services, and other issues did not perform their work in accordance with industry and professional standards, resulting in significant internal control issues and losses for NHC.

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184. Larson should have planned its audit procedures, taking into account the internal control weaknesses evident at NHC.

185. However, Larson did not adequately plan for, search for, identify, or disclose these internal control weaknesses.

186. Both the 2013 and 2014 financial reports submitted to the Nevada DOI attached supplemental information, including respective MD&A's, which were subject to Larson's auditing procedures.

187. The MD&A's however, were at best deficient prohibited boilerplate that did not conform to statutory, industry or NAIC requirements and neither discussed nor disclosed significant issues concerning, without limitation, NHC's extraordinary accounting practices, insufficient reserves, liquidity concerns, lack of borrowing capacity or its inability to continue as a going concern, as set forth herein.

188. On or about May 29, 2014, Larson issued its audit report for the year ended December 31, 2013 (the "2013 Opinion"). The 2013 Opinion contained no information concerning NHC's ability to continue as a going concern, despite the fact that by the time the report was issued, NHC was incurring substantial unanticipated losses. Neither did the 2013 audit report disclose the significant internal control weaknesses that existed or recognize adequate reserves for the contracts on which NHC was already incurring substantial losses.

189. On or about June 1, 2015, Larson issued its Statutory Financial Statements and Independent Auditor's Report and other Legal and Regulatory Information (the "2014 Audit Opinion") regarding NHC's 2013 and 2014 financial statements.

190. The 2014 Audit Opinion contained one emphasis of matter paragraph noting only issues with the Risk Adjustment, the Federal Transitional Reinsurance, and the Risk Corridor programs. Despite the materiality of receivables from the federal government, and the issues raised concerning their calculation, the 2014 Audit Opinion stated that, "[Larson's] opinion is not modified with respect to this matter."

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191. The 2014 Audit Opinion was without any qualification as to the reported reserves, the recording of loan receipts in the year prior to actual receipts, internal control weaknesses, or NHC's ability to continue as a going concern.

192. On or about June 1, 2015, Larson issued its Reports of Independent Certified Public Accountants Required by OMB Circular A-133 for the Year Ended December 31, 2014 (the "2014 OMB Report"), which included its analysis of internal controls for the purpose of expressing its opinion on the financial statements.

193. In the 2014 OMB Report, Larson stated that during its audit, it did not identify any deficiencies in internal control that it considered to be material weaknesses.

194. Additionally, in the 2014 OMB Report, Larson represented that, as part of obtaining reasonable assurance about whether NHC's financial statements were free from material misstatements, it performed tests of NHC's compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have had a direct and material effect on the determination of financial statement amounts.

195. In the 2014 OMB Report, Larson further stated the results of its tests disclosed no instances of noncompliance or other matters that were required to be reported under government auditing standards.

196. As part of the 2014 OMB Report, Larson also included an Independent Auditor's Report on Compliance for Each Major Program; Report on Internal Control over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by OMB Circular A-133 ("the 2014 Major Program Report").

197. In the 2014 Major Program Report, Larson reported that, in its opinion, NHC complied in all material respects with the types of compliance requirements referred to in the report that could have had a direct and material effect on each of its major federal programs for the year ended December 31, 2014; that it did not identify any deficiencies in internal control over compliance that it considered to be material weaknesses; and that, in its opinion, the schedule of expenditures of federal awards was fairly stated in all material respects in relation to the statutory financial statements taken as a whole.

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I. The Larson Defendants' Work Failed to Meet Statutory and Professional Standards Required of CPAs.

198. In performing its audits of NHC and in providing other accounting services to NHC, Larson failed to meet statutory and professional standards, including, but not limited to those set forth herein.

199. Larson did not properly identify or disclose the reliance of NHC on extraordinary state prescribed or permitted practices, whether such prescribed or permitted practices were approved, or whether the reporting entity's risk based capital ratios would have triggered a regulatory event had it not used a prescribed or permitted practice.

200. Larson failed to identify and adequately disclose that material transactions, including the posting of a multi-million dollar receivable from a loan that had not even been formally applied for, were recorded in the year prior to formal application and receipt.

201. Larson failed to identify and disclose that as of December 31, 2013, and 2014, NHC's ability to continue as a going concern was in doubt.

202. Larson failed to adequately identify and disclose that NHC's insurance reserves including its PDR as of December 31, 2013, and 2014, and IBNR reserves as of December 31, 2014, were materially misstated.

203. Larson failed to adequately analyze and test work performed by NHC's actuary.

204. Larson failed to identify and disclose related party transactions.

205. Larson failed to identify and disclose internal control deficiencies, including but not limited to financial reporting controls, as well as internal controls relating to claims, enrollment, member termination, premium tracking, and provider arrangements.

206. Larson failed to identify and disclose violations of loan covenants and NHC's inability to repay existing debt.

207. Larson failed to identify or properly assess business risks, including but not limited to insufficient premium rates to support the policies issued, inadequate information technology systems and vendors, problems with processing and paying claims, issues with billings for premiums, issues with processing premium payments, and a lack of additional borrowing capacity.

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208. Larson failed to identify, plan for, or disclose NHC management's lack of experience and competence to produce financial statements that were in conformance with applicable reporting standards and free from material misstatements.

209. Larson failed to adequately test, disclose and report the collectability and reserves for material receivables.

210. Larson failed to prepare an adequate audit plan or to even follow the inadequate audit plan that it prepared.

211. Larson failed to perform proper subsequent events testing and did not identify or disclose numerous subsequent events that should have been considered in analyzing year-end account balances and that should have been disclosed in the financial statements.

212. Larson failed to identify or disclose deficient MD&A information and disclosures contained in the supplemental information provided with NHC's 2013 and 2014 financial statements.

213. Larson also failed to properly document and maintain appropriate audit evidence in support of any audit work it performed.

FACTUAL ALLEGATIONS RELATING TO THE INSUREMONKEY DEFENDANTS

J. InsureMonkey is Engaged by NHC Based on its Claimed Expertise.

214. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

215. In 2013, NHC sought a qualified contractor to provide software and services, including a customer portal to enroll and to service NHC's customers. The software and services would also collect and provide to NHC data necessary for making operational decisions and reporting to regulators.

216. Defendants Rivlin and InsureMonkey represented to NHC that InsureMonkey was qualified and capable of providing the software and services.

217. On or about April 13, 2013, NHC and InsureMonkey entered into a Memorandum of Understanding for InsureMonkey to provide the technology and software services. NHC and InsureMonkey subsequently entered into a Master Services Agreement relating to technology and

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services, making the agreement effective as of the date of the earlier Memorandum of Understanding (the "2013 Master Services Agreement"). Rivlin largely negotiated and executed the 2013 Master Services Agreement on behalf of InsureMonkey.

218. As part of the 2013 Master Services Agreement, InsureMonkey expressly acknowledged that it was required to "comply with [NHC's] obligations" under NHC's CMS Loan Agreement as part of performing InsureMonkey's services. Similarly, InsureMonkey acknowledged that it had to maintain certain records and provide NHC, CMS, and others with access to certain information relating to InsureMonkey's performance under the 2013 Master Services Agreement.

219. In a similar timeframe, NHC was also searching for a contractor to perform additional customer service functions, including establishing a call center and providing support to consumers involved in the enrollment process.

220. During this April-May 2013 time period, InsureMonkey's representatives, especially its CEO Rivlin, expressly represented that InsureMonkey was capable of providing all of the additional customer service support functions that NHC was seeking, in addition to its technological and software support.

221. From June through August 2013, NHC and InsureMonkey continued to negotiate terms of a customer services contract to handle both on-exchange and off-exchange support services. Again, during this time, InsureMonkey's representatives, including Rivlin, repeatedly touted InsureMonkey's capabilities in the customer service space relating to the insurance business.

222. On or about August 1, 2013, NHC and InsureMonkey entered into another Memorandum of Understanding governing InsureMonkey's provision of customer service functions to NHC (the "August 2013 Customer Service MOU"). Rivlin negotiated and executed the August 2013 Customer Service MOU on behalf of InsureMonkey.

223. The August 2013 Customer Service MOU required InsureMonkey to deliver "contact center service…for new and renewing member enrollments" on behalf of NHC. This included providing, staffing, and operating both a call center and a walk-in center for consumers.

224. The August 2013 Customer Service MOU represented that InsureMonkey would provide "professionally licensed and trained Contact Center Agents" and that InsureMonkey would

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"train all Agents on NHC products and enrollment processes as well as enrollment processes" through the exchange, "including determining subsidy eligible populations and providing eligibility" through the exchange.

225. Upon information and belief, when Rivlin and other representatives of InsureMonkey made representations regarding the services they could and would perform, they either had no intention of fulfilling those obligations and/or should have reasonably understood that InsureMonkey was unable to adequately perform the critical services they were contracting to perform on behalf of NHC. As a result, InsureMonkey knew or should have known that its failure necessarily would have impacted NHC's status with CMS and the loan proceeds NHC was to obtain under the CMS Loans Agreement.

226. On or about September 3, 2013, InsureMonkey and NHC entered into an additional Memorandum of Understanding further expanding InsureMonkey's responsibilities and obligations with respect to customer and member services (the "September 2013 Customer Service MOU"). Yet again, this agreement was predicated upon the express representations of Rivlin regarding InsureMonkey's capabilities with respect to these types of services.

227. Among other things, the September 2013 Customer Service MOU detailed NHC's obligations with respect to developing "a comprehensive model of member services that addresses all aspects of stakeholder management." In addition to providing a member services center on behalf of NHC, InsureMonkey agreed that it would track certain information regarding members, their eligibility status, and other contacts relating to information and data that needed to be reported to CMS.

228. InsureMonkey performed services under its agreements with NHC relating to the 2013 enrollment period for 2014 coverage.

229. During this time, NHC relied upon InsureMonkey's ability to perform its services and on the reporting and tracking data provided to it by InsureMonkey in submitting reports and information to CMS.

230. On or about August 1, 2014, NHC and InsureMonkey entered into a Master Services Agreement "to consolidate the terms of their continuing business relationship under the terms of

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this Agreement" and to set forth the scope of the parties' relationship moving forward (the "Master Agreement"). Rivlin again negotiated and executed the Master Agreement on behalf of InsureMonkey.

231. Like the prior agreements, InsureMonkey expressly represented in the Master Agreement that it would "comply with the terms of the [CMS] Loan Agreement" in performing its obligations to NHC.

232. InsureMonkey represented in the Master Agreement that the "[s]ervices contemplated hereunder will be performed by adequately trained, competent personnel, in a professional manner, with such personnel having the requisite skill and expertise necessary to perform and complete the Services in accordance with industry standards[.]"

233. InsureMonkey also represented in the Master Agreement that the "[s]ervices will substantially conform to the applicable specifications and acceptance criteria (if any) agreed to by the parties in the applicable Statement of Work[.]"

234. Throughout the relationship between InsureMonkey and NHC, because of the inexperience of NHC management and the representations of InsureMonkey as to its superior knowledge and expertise, NHC trusted, relied on, and depended on InsureMonkey as a key component of its operation in its business of insuring and servicing NHC's Members.

235. At the time Rivlin executed the Master Agreement, he and InsureMonkey knew or reasonably should have known that that they had no intention or ability to honor the terms of the Master Agreement, that InsureMonkey would not and could not perform the services contemplated by the Master Agreement in accordance with industry standards, and that InsureMonkey did not have adequately trained and competent personnel to perform such service.

K. InsureMonkey Fails to Perform Under its Agreement and Misrepresents Key Data that NHC Relied upon in Reporting to CMS.

236. Under the parties' agreements, NHC was largely left to the mercy of InsureMonkey. InsureMonkey was responsible for reporting current, complete, and accurate enrollment, billing, and eligibility data, upon which NHC was to rely in servicing its members and in making its reports to CMS, the Nevada DOI, and others.

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237. InsureMonkey failed to follow industry standards relating to tracking and reporting basic enrollment, billing, and eligibility data, including without limitation the failures set forth herein.

238. At critical times during the open enrollment process, InsureMonkey was unable to make the broker portal it had created work properly and allow agents to sign up individuals for insurance policies. These portal issues impacted and depressed enrollment numbers in both 2014 and 2015, leading to fewer members being insured under the plan and lower premium income for NHC.

239. InsureMonkey failed to attend regular CMS information calls on NHC's behalf, which it was contractually required to do, leading to NHC failing to receive necessary information from CMS that InsureMonkey was obligated to obtain and transmit.

240. InsureMonkey failed to submit monthly reconciliation files to CMS for many months as required, impacting the receipt of premium subsidies from CMS.

241. InsureMonkey failed to hire qualified individuals to provide the customer and member services as contemplated by the parties' agreements.

242. InsureMonkey failed to properly train individuals to provide the customer and member services contemplated by the parties' agreements.

243. InsureMonkey failed to properly supervise individuals providing the customer and member services contemplated by the parties' agreements.

244. InsureMonkey failed to properly log eligibility data for individuals during the enrollment process.

245. InsureMonkey failed to obtain premium payments from new and renewing members or to transmit that information in a timely manner.

246. InsureMonkey failed to timely terminate members' eligibility when they became ineligible for benefits under the plan.

247. InsureMonkey failed to timely transmit information regarding premiums received, causing the improper suspension of insureds' coverage and terminating or negatively affecting premium subsidies that NHC would otherwise have received from CMS.

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248. InsureMonkey even failed at the most basic level in reporting the total number of enrollees in the plan.

249. When the incompetency of InsureMonkey's employees was brought to InsureMonkey's attention, InsureMonkey failed to retrain or replace those individuals, and it allowed them to continue to provide deficient customer and member services.

250. As a result of InsureMonkey's incompetency despite its representations to the contrary, as well as its deficient hiring, training, supervision, and retention of employees, InsureMonkey's performance under the agreements was woefully deficient.

251. InsureMonkey had an incentive to over report the number of members enrolled in the plan at any given time and to not terminate a member's eligibility in NHC's books and records.

252. Notably, several of the parties' agreements, including the Master Agreement, calculated the payment due to InsureMonkey from NHC based on a certain price per member, per month that the member was enrolled in the plan.

253. Upon information and belief, InsureMonkey, at the direction of its CEO Rivlin, intentionally misrepresented the membership enrollment numbers in order to procure larger payments to InsureMonkey under their agreements.

254. At the time, NHC had no reason to know or suspect the extent of InsureMonkey's failure to properly report enrollment, billing, and eligibility data or its deliberate misreporting of enrollment, billing, and eligibility data. NHC only learned of the extent of InsureMonkey's misreporting after the appointment of a receiver over NHC.

255. Despite its woefully deficient performance, InsureMonkey was paid approximately $4.4 million for contracted services in 2014 and over $5 million in 2015.

256. InsureMonkey's actions and conduct addressed herein resulted in grave consequences to NHC. Without limitation, InsureMonkey's actions led to the following: (a) underpayment to NHC for advanced premium tax credits that NHC would have been entitled to had InsureMonkey properly performed its services and provided reliable data concerning enrollment to NHC and CMS; (b) NHC paying out additional claims as a proximate result of InsureMonkey's reporting of faulty eligibility data; (c) NHC overpaying into the transitional reinsurance program as

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the proximate result of InsureMonkey's reporting of faulty eligibility data; (d) NHC overpaying InsureMonkey and other contractors in payments calculated on faulty enrollment data provided by InsureMonkey; and (e) decreased risk corridor payments to NHC as the proximate result of InsureMonkey providing faulty and unreliable enrollment data.

FACTUAL ALLEGATIONS RELATING TO NEVADA HEALTH SOLUTIONS

L. NHS Engages with Kathleen Silver in Self-Dealing, Receiving Substantial Sums for Deficient Utilization Management Services.

257. Plaintiff realleges and incorporates all of the allegations contained in the proceeding paragraphs as is fully set forth herein.

258. Utilization management is the evaluation of appropriateness and medical necessity of health care services, procedures and facilities according to evidence-based criteria or guidelines, and under the provisions of an applicable health insurance plan.

259. NHS represented itself to be a capable utilization management services company.

260. Pursuant to a Utilization Management Services Agreement (the "Utilization Agreement"), NHS contracted with NHC to perform evaluations of appropriateness and medical necessity of heath care services, procedures and facilities; perform precertification of hospital admissions and outpatient procedures; process information related to in-hospital observations; provide concurrent reviews for inpatient acute care, rehabilitation and long term acute care; provide discharge planning; and perform provider appeal reviews, along with other services. NHS was also engaged to perform member eligibility review services for NHC, a process through which the enrollment of NHC's members must be verified for medical benefits to be allowed by NHC.

261. Throughout the relationship between NHS and NHC, because of the relative inexperience of NHC management (well known to NHS) and the representations of NHS as to its superior knowledge and expertise, NHC trusted, relied on, and depended on NHS as its gatekeeper to ensure the appropriateness and medical necessity of medical services incurred by NHC's members and their eligibility for such services.

262. NHS breached the Utilization Agreement by failing to perform contracted work and by failing to perform to applicable contractual, professional and industry standards. Without

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limitation, NHS failed to perform to the standards set forth in the Utilization Management Program that was incorporated into the Utilization Agreement.

263. Under the Utilization Agreement, NHS was to perform its services utilizing appropriate medical staff including accredited physicians. On information and belief, NHS did not employ qualified personnel to perform the contracted services, and at most subcontracted such services to others, to the extent they were performed at all.

264. Initial compensation was mechanically calculated based on the total persons enrolled as NHC members each month, a fee that bore little to no relation to services being provided by NHS. Upon information and belief, little work was actually performed by NHS for NHC.

265. Fees under the Utilization Agreement were charged by NHS on a per member per month basis, but NHS required a minimum monthly fee to be paid based on an enrolled membership of 10,000 members. NHC did not have 10,000 enrolled members for the first four months of 2014 and was substantially short of 10,000 enrolled members in those months; thus, NHC paid the minimum monthly fee to NHS in each of those first four months of 2014. Additionally, NHC was to be charged by NHS for all direct and indirect provider costs incurred by NHS for performing its services. However, since NHS provided little services to NHC in 2014, there were no other direct or indirect costs charged by NHS to NHC other than the per member per month flat monthly fee stated above. On information and belief, NHS failed to adjust for the actual cost of the limited work performed.

266. NHS and Management Defendant Kathleen Silver engaged in self-dealing in which NHS was unjustly paid substantial amounts by NHC for the so-called utilization management services. NHS's president was Management Defendant Kathleen Silver, and upon information and belief, the owner of NHS was UHH. Upon information and belief, UHH was an entity with financial ties and/or direct or indirect business links with Management Defendants Bobbette Bond, Thomas Zumtobel, and Kathleen Silver. UHH was being paid to process and adjudicate claims of NHC, and then it was being paid again through NHS to do a quality control review check of the very claims that UHH processed. The NHS and NHC medical utilization management review arrangement was unfair, unreasonable, and just another way to siphon more money out of NHC to the detriment of its members, policyholders, and creditors.

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267. NHS's actions and conduct resulted in substantial losses to NHC. Without limitation, in excess of $1 million in claims were paid outside of enrollment when NHS failed to properly perform eligibility checks during utilization reviews. NHS was paid fees and expenses totaling $382,968 under this utilization management and enrollment eligibility review arrangement. Costs which should not have been incurred under the Utilization Management Program were incurred, contracted assistance to members for managing health care decisions was not received, and inappropriate financial benefits were paid from this arrangement to the detriment of NHC's members, policyholders, and creditors.

FACTUAL ALLEGATIONS RELATING TO THE MANAGEMENT DEFENDANTS

M. The Management Defendants Fail to Uphold Their Fiduciary Duties to NHC.

268. Plaintiff realleges and incorporates all of the allegations contained in the proceeding paragraphs as is fully set forth herein.

269. As officers and directors of NHC, each of the Management Defendants owed duties of good faith and loyalty to NHC and was charged with exercising his or her powers, authority, and discretion in the best interests of NHC.

270. Additionally, the Management Defendants executed employment agreements and ethics and conflicts of interest documents which contractually specified such duties.

271. The duties owed by the Management Defendants included, without limitation, not misleading regulatory authorities, instituting adequate internal controls to protect company assets and operations, adequately selecting and supervising employees and contractors, avoiding self-dealing, fully and adequately disclosing related party transactions, avoiding the squandering of NHC's assets, and reviewing and ensuring the accuracy of loan applications, financial statements, and regulatory filings submitted by NHC.

272. From NHC's inception through its being put in receivership in October 2015, as outlined below, each of the Management Defendants failed to uphold his or her duties owed to NHC when exercising his or her powers and authority with respect to the business decisions, operations, reporting and management of NHC.

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N. Management Defendants Unreasonably Fail to Establish Internal Controls, Exercise Oversight, Ensure Accurate Reporting, or Adequately Disclose Related Party Transactions.

273. A primary responsibility of Management Defendants was to institute sufficient internal controls to ensure the protection of assets, to establish and enforce procedures to run NHC, and to conform with statutory requirements, including providing accurate reporting to regulators and the public.

274. The Management Defendants failed to establish sufficient internal controls over its business.

275. Initially, the Management Defendants failed to hire or train adequate personnel to run its business. As a result, NHC relied on contractors to perform critical processes for NHC, creating another set of internal control concerns, ones that were likewise overlooked and ignored by the Management Defendants.

276. Rather than prudently limiting the scope of business until such time as adequate internal controls had been established, the Management Defendants appear to have adopted an "even if we lose money on each customer we will make it up in volume" approach.

277. Contractors handling enrollment, claims processing, billing, receipt of premiums, premium rate setting, actuarial services, and other issues did not perform their work in accordance with industry and professional standards, resulting in significant internal control issues and losses for NHC, issues that should have been caught and remedied by the Management Defendants, but were not.

278. Additionally, the total breakdown in internal controls caused misleading reports to be issued in violation of applicable statutes and standards.

279. The Management Defendants knew or should have known of the dearth of internal controls to protect NHC and the public. The Management Defendants' refusal to institute such controls involved and/or constituted negligence, intentional misconduct, fraud, and/or knowing violations of the law.

280. The Management Defendants similarly failed or refused to exercise the necessary required oversight of NHC and its contractors.

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281. Employees without the expertise or experience to run such a large undertaking were negligently hired and retained, or were simply allowed to keep positions given to them by the Culinary Health Fund.

282. As discussed herein, rather than replacing or obtaining sufficient training for its employees, the Management Defendants engaged contractors whose work was not properly performed or appropriately overseen.

283. Even when significant problems arose, the Management Defendants failed to exercise their oversight function and remedy them.

284. Contractors created overly optimistic feasibility studies, on information and belief, in order to receive compensation that would only be paid if loans were received.

285. Early in the process, NHC's officers and directors, including each of the Management Defendants, authorized and/or ratified financial transactions and assumed financial obligations that they knew or should have known NHC could not meet or otherwise satisfy.

286. Customers had difficulty signing up for services, premiums went unbilled or unpaid, failures in reporting data to CMS caused government subsidies to be lost, and vendors were paid despite failing to perform under contracts. Insureds failed to receive coverage because of bad data, and costs were paid because NHC could not confirm whether coverage was or was not in effect. Still, the Management Defendants failed to exercise appropriate oversight to remedy the situation.

287. Despite horrendous losses, the Management Defendants authorized NHC to continue to draw down on government loans, knowing there was no reasonable way that such loans could be repaid.

288. As further discussed herein, the Management Defendants, including the audit committee members, the chief financial officer, and NHC's president, also failed to exercise oversight to ensure accurate, truthful, and non-misleading dissemination of financial information to regulatory authorities and the public with respect to NHC's affairs.

289. The Management Defendants knew or should have known that their intentional decision not to exercise appropriate oversight would cause significant damages and would involve and/or constitute negligence, intentional misconduct, fraud, and/or knowing violations of the law.

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290. The Management Defendants' actions or inactions similarly caused misleading reporting of financial and operational results to the Nevada DOI and others.

291. From 2012 through 2015, the Management Defendants retained and/or approved the retention of certain third party entities to perform financial reporting and/or auditing on behalf of NHC, including, but not limited to Milliman, Millennium, and Larson.

292. In early 2015, a preliminary report was filed with the Nevada DOI for the year ended December 31, 2014.

293. As discussed above, NHC's reserve levels raised concerns with the Nevada DOI, and throughout early 2015 the Nevada DOI went to extraordinary lengths to communicate clear guidance for the proper calculation of reserves. Nevada DOI guidance went directly to NHC management.

294. Additionally, the NAIC pointed out deficiencies in NHC's statutory reporting directly to NHC's management.

295. The Nevada DOI stated they expected the PDR to be re-evaluated on a quarterly basis and adjusted as necessary if the emerging experience was substantially different from the projected experience. These steps were not taken and, in fact, the PDR calculation appears to have been skipped at the end of the first quarter, contrary to the Nevada DOI's explicit request and prior to the issuance of certain audits and financial reports adopted, ratified, and/or disseminated by the Management Defendants.

296. The balances of the reserves should have been questioned and audited by the Management Defendants, both from a year-end review perspective and as part of NHC's management, audit committee, and overall oversight responsibilities, yet there is no evidence that any such actions were taken, and the Management Defendants issued later reports without adjustment.

297. Even without adjusting reserve balances, NHC had reported losses of over $8 million in 2013 and over $16 million in 2014.

298. Up until NHC issued reports on June 1, 2015, NHC continued to hemorrhage losses under the direction, guidance, and management of the Management Defendants.

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299. NHC had all but exhausted its remaining capital by that time.

300. NHC exhausted what remained of its almost $66 million in CMS loans in early 2015, and had no borrowing capacity remaining given its huge losses.

301. As previously mentioned, the amount of a draw on the CMS Loans, that had not been formally applied for in 2014, was recorded as a receivable in the 2014 annual financial reports without adequate disclosure.

302. At a minimum, NHC's Audit Committee members, including Defendant Bond, knew, or should have known that recording of a receivable for a loan in the year before it was formally applied for, without disclosure, was misleading, could artificially inflate NHC's reported surplus levels, and could make NHC appear more solvent than it actually was.

303. These issues should all have been obvious "red flags" to the Management Defendants, and they should have been disclosed, along with the fact that NHC would be unable to continue as a going concern. They should also have resulted in appropriate remedial measures.

304. The Management Defendants knew or should have known that their intentional decision not to properly address red flags raised by regulators, as well as the obvious deficiencies of NHC's financial reports, would cause significant damages and involve and/or constitute negligence, intentional misconduct, fraud, and/or knowing violations of the law.

305. Additionally, the Management Defendants drafted or ratified and approved of the release of the 2013 and 2014 MD&A's. These documents, which are intended to disclose and serve as management's discussion and analysis of important issues facing NHC, failed to disclose or analyze important issues, including without limitation, NHC's extraordinary accounting practices, insufficient reserves, liquidity concerns, lack of borrowing capacity or its inability to continue as a going concern. The failure of management to adequately disclose or analyze these and other issues was in violation of statutory and industry requirements, including those set forth by the NAIC, the Nevada DOI and incorporated into Nevada law.

306. The Management Defendants did not ensure proper reporting of related party transactions.

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307. NHC management had extensive connections with the Culinary Union and its UHH administrator. Many of the Director Defendants had served on the Board of the Culinary Health Fund, and some Directors also had positions with the Culinary Union. NHC hired UHH to administer the medical side of NHC's business. As a result, UHH was paid significant fees that, on information and belief, provided a windfall for UHH.

308. Defendant Kathy Silver served as a director of NHC and was president of two Culinary Union related entities, NHS and the Culinary Health Fund.

309. As discussed above, NHC management engaged NHS to perform utilization management and member eligibility review services for NHC in 2014. NHC paid substantial fees to NHS for this service, receiving limited and deficient services in return. NHS also had a conflict of interest, or the appearance of a conflict of interest, by being engaged to provide a quality control review of claim services provided by its parent company, UHH.

310. Despite requirements to disclose these related party transactions in financial statements and other filings to the Nevada DOI, CMS and others, NHC management failed to adequately provide such disclosure.

311. NHC management also paid themselves exorbitant compensation without justification and despite the fact that NHC was losing millions of dollars each financial report period.

312. Due to the material amounts of funds flowing from NHC to UHH and NHS, the Management Defendants were under an obligation to report the related party transactions in NHC's financial statements, and they were under a further obligation to assure that these related party transactions were fair and reasonable to NHC. The Management Defendants, however, failed to do so.

313. Management Defendants, including but not limited to Egan, Dibsie and Mattoon, authorized or caused to be paid claims outside of eligibility, in violation to their fiduciary duties to NHC, resulting in substantial losses to NHC.

314. Such acts and omissions with respect to NHC's failure to adequately disclose related party transactions and to assure their fairness, paying claims outside of eligibility, along with paying themselves unreasonable compensation, by the Management Defendants involved and/or constituted intentional misconduct, fraud, self-dealing, and/or the knowing violation of the law.

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O. The Financial Collapse of NHC and the Resulting State Rehabilitation and Liquidation Proceedings.

315. Ultimately, no one could deny that NHC was incapable of continuing as a going concern, and the Nevada DOI was required to step in. On August 17, 2015, NHC's board of directors voted to cease writing new business and to suspend voluntarily its certificate of authority, effectively "throwing in the towel" and ending any prospect of recovery.

316. On September 25, 2015, and with the consent of NHC's board of directors, a petition for appointment of Commissioner as Receiver and Other Permanent Relief; Request for Injunction Pursuant to NRS 696 B.270(1) was filed by the then acting Nevada Commissioner of Insurance, Amy L. Parks, in her official capacity as Temporary Receiver of the Nevada Health CO-OP.

317. An Order Appointing the Acting Commissioner of Insurance, Amy L. Parks, as Temporary Receiver Pending Further Orders of the Court, Granting Temporary Relief Pursuant to NRS 696B.270, and authorizing the Temporary Receiver to appoint a special deputy receiver was filed on October 1, 2015. The Commissioner, as Temporary Receiver, appointed the firm of Cantilo & Bennett, L.L.P. as Special Deputy Receiver on October 1, 2015.

318. On October 14, 2015, the Court issued a Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health CO-OP. On September 21, 2016, the Court issued a Final Order Finding and Declaring Nevada CO-OP to be insolvent and placing Nevada Health CO-OP into Liquidation.

319. Under these orders the Commissioner of Insurance (as the Permanent Receiver) and Cantilo & Bennett (as the Special Deputy Receiver) are authorized to liquidate the business of NHC and wind up its ceased operations pursuant to NRS 696B.220.2. This authority includes authorization to institute and to prosecute, in the name of the CO-OP or in the receiver's own name, any and all suits and other legal proceedings, and to prosecute any action which may exist on behalf of the members, enrollees insured, or creditors, of CO-OP against any person.

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320. The consequences of Defendants' actions were not simply academic. Over $65 million in federal loans are in default. Medical insurance for tens of thousands of people was disrupted; doctors and hospitals went unpaid; and insured patients were left concerned about receiving needed care and whether they would be able to pay medical bills.

321. The Receiver is now tasked with liquidating the failed insurer to protect members, insured enrollees, and creditors of NHC and the public.

CAUSES OF ACTION RELATED TO MILLIMAN DEFENDANTS

FIRST CAUSE OF ACTION

(Negligence Per Se - Violation of NRS 681B Against Milliman and Heijde)

322. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

323. NRS 681B requires, in part, the opinion of an appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of the State of Nevada.

324. NRS 681B also prescribes minimum standards of form and substance for the opinion, including those set forth in the Valuation Manual adopted by the NAIC.

325. Plaintiff and those represented by Plaintiff, including the members of NHC, NHC's insured enrollees, NHC's creditors, NHC, and the State of Nevada belong to a class of persons that NRS 681B was designed to protect.

326. Milliman and Heijde accepted appointment as NHC's appointed actuary, and provided opinions under NRS 681B.

327. As a result, Milliman and Heijde were subject to the minimum standards as set forth in NRS 681B.

328. As set forth above, Defendants Milliman and Heijde violated NRS 681B by failing to perform their duties as the appointed actuary in accordance with the applicable minimum statutory and applicable professional standards.

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329. Plaintiff's injury was the type against which NRS 681B was intended to protect.

330. As a direct and proximate result of Defendants Milliman and Heijde's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

331. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SECOND CAUSE OF ACTION

(Professional Malpractice Against Milliman Defendants)

332. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

333. The Milliman Defendants were engaged by NHC and its predecessors in interest to provide professional actuarial services to NHC.

334. Such services included but were not limited to providing certification required pursuant to NRS 681B, conducting a feasibility study, providing business plan support, assisting NHC in setting premium rates, participating in the preparation of financial reports and information to regulators, and establishing policies of insurance as set forth herein.

335. The Milliman Defendants had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

336. As detailed above, the Milliman Defendants breached that duty by failing to comply with applicable statutory and professional standards including those set forth in NRS 681B, the Valuation Manual adopted by the NAIC, the ASOPs as adopted by the Actuarial Standards Board of the American Academy of Actuaries, and by taking actions that caused the misreporting of the 2014 financial results without reasonable basis.

337. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

338. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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THIRD CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against Milliman Defendants)

339. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

340. On or about December 21, 2011 Milliman and Shreve issued a document entitled "Hospitality Health Feasibility Study and Business Support for Consumer Operated and Oriented Plan (CO-OP) Application."

341. On or about March 1, 2015 and on or about May 14, 2015, Milliman and Heijde issued the valuation and certification of NHC's reserves pursuant to NRS 681B.

342. In each of these documents, the respective Milliman Defendants certified that the statements contained therein were, to the best of their knowledge and belief, accurate, complete, and prepared in accordance with generally recognized and accepted actuarial principles and practices consistent with ASOPs, the Code of Professional Conduct and Qualification Standards for Public Statements of Actuarial Opinion of the American Academy of Actuaries.

343. The Milliman Defendants knew or believed that these representations were false, or that they had an insufficient basis of information for making them.

344. Milliman also participated in the preparation of 2014 financial information to the Nevada DOI insurance regulators for 2014 that presented and represented NHC's financial condition, and this information was misleading, false, without sufficient basis, and misreported the financial information of NHC.

345. Plaintiff justifiably relied upon the Milliman Defendant's representations.

346. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

347. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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FOURTH CAUSE OF ACTION

(Constructive Fraud Against Milliman Defendants)

348. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

349. At all relevant times, the Milliman Defendants had a fiduciary and/or confidential relationship with NHC.

350. The Milliman Defendants owed a legal or equitable duty to Plaintiff arising from a fiduciary or confidential relationship.

351. The Milliman Defendants breached that duty by misrepresenting or concealing a material fact, i.e. that the Milliman Defendants had not performed their services in accordance with applicable statutory and professional standards as set forth herein and that as a result NHC should not have relied on their conclusions, advice and opinions.

352. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

353. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTH CAUSE OF ACTION

(Negligent Misrepresentation Against Milliman Defendants)

354. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

355. The Milliman Defendants, in a course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff as set forth above.

356. Such information included, without limitation, the information set forth in the Feasibility Study, the calculation of premiums, the calculation of financial projections, the calculation of required reserves, and the communication of financial information to the Nevada DOI insurance regulators.

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357. Plaintiff justifiably relied on this information it received.

358. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

359. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTH CAUSE OF ACTION

(Breach of Fiduciary Duty Against Milliman Defendants)

360. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

361. A fiduciary duty existed between Plaintiff and the Milliman Defendants where Milliman was in a superior or trusted position as set forth herein.

362. The Milliman Defendants breached that duty by failing to perform to statutory and professional standards as set forth above.

363. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

364. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SEVENTH CAUSE OF ACTION

(Negligence Against Milliman Defendants)

365. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

366. The Milliman Defendants owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable statutory and professional standards.

367. As detailed above, by failing to perform to applicable statutory and professional standards, the Milliman Defendants breached that duty.

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368. The breach was the legal cause of Plaintiff's injuries.

369. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

370. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

EIGHTH CAUSE OF ACTION

(Breach of Contract Against Milliman)

371. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

372. Milliman and Hospitality Health entered into a valid and enforceable contract - the Consulting Services Agreement - that required Milliman to perform professional actuarial services.

373. A provision of the Consulting Services Agreement states, "Milliman will perform all services in accordance with applicable professional standards."

374. Plaintiff was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health.

375. Milliman failed to perform under the Consulting Services Agreement by failing to perform actuarial services as required under applicable professional and statutory standards, as detailed above.

376. Plaintiff performed or was excused from performance under the Consulting Services Agreement.

377. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

378. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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NINTH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against Milliman)

379. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

380. Milliman and Hospitality Health entered into a valid and enforceable contract - the Consulting Services Agreement - that required Milliman to perform professional actuarial services.

381. Plaintiff was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health.

382. Milliman owed a duty of good faith to Plaintiff arising from the contract.

383. A special element of reliance or fiduciary duty existed between Plaintiff and Milliman where Milliman was in a superior or trusted position.

384. Milliman breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the Consulting Services Agreement, by failing to perform in accordance with statutory and professional standards as set forth herein.

385. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

386. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TENTH CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against Milliman)

387. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

388. Milliman and Hospitality Health entered into a valid and enforceable contract - the Consulting Services Agreement - which required Milliman to perform professional actuarial services.

389. Plaintiff was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health.

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390. Under applicable law, the Consulting Services Agreement contains an implied covenant of good faith and fair dealing among all parties.

391. Milliman, by failing to follow applicable professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Consulting Services Agreement.

392. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

393. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

ELEVENTH CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Milliman Defendants)

394. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

395. The Milliman Defendants undertook to provide actuarial services, including but not limited to providing a feasibility study, calculating insurance premiums, performing other forecasts, calculating and certifying required reserves and other actuarial items, and participating in the preparation of financial information and reports that would be submitted to the Nevada DOI insurance regulators.

396. The Milliman Defendants knew or should have recognized these undertakings as necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

397. By performing the actuarial services detailed above, the Milliman Defendants undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors and regulators to act in accordance with statutory and professional standards, to properly compute premiums, to properly perform feasibility studies and forecasts, to properly value the reserves and other actuarial items of NHC, and to submit proper and reasonable reports of financial condition.

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398. The Milliman Defendants' failure to exercise reasonable care in performing its services, including their failure to perform actuarial services in accordance with applicable standards as detailed herein, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada, and it unnecessarily prolonged, and it led to, the continued and unjustified existence of NHC.

399. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

400. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWELFTH CAUSE OF ACTION

(Unjust Enrichment Against Milliman)

401. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

402. Milliman was paid over $1 million for actuarial services that were to be performed in accordance with statutory and professional standards.

403. Despite failure to provide such services in accordance with statutory and professional standards, Milliman unjustly retained the fees paid to it for such services against fundamental principles of justice, equity, and good conscience.

404. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

405. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTEENTH CAUSE OF ACTION

(Civil Conspiracy Against Milliman Defendants)

406. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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407. Defendants Milliman and Shreve acted in concert with each other and with the management of NHC, including, but not limited to, Dibsie, to obtain funds for NHC under false pretenses and to license NHC through the use of the Feasibility Study, which they knew to be false and not in accordance with required statutory and professional actuarial standards.

408. Defendants Milliman and Heijde acted in concert with each other and with management of NHC, including, but not limited to, Egan and Dibsie, to falsify reserves and financial reporting and avoid statutory supervision by their use of the 2014 Opinion, participated in the preparation of false and misleading financial information that was provided to Nevada DOI insurance regulators, and had subsequent communications with NHC and/or Nevada DOI insurance regulators, which they knew to be false and not in accordance with required statutory and professional standards.

409. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

410. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FOURTEENTH CAUSE OF ACTION

(Concert of Action Against Milliman Defendants)

411. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

412. Defendants Milliman and Shreve acted in concert with each other and the management of NHC, including, but not limited to, Dibsie, to obtain money under false pretenses and license NHC through use of the Feasibility Study, which they knew to be false and not in accordance with required statutory and professional actuarial standards.

413. Defendants Milliman and Heijde acted in concert with each other and the management of NHC, including Egan and Dibsie, to falsify reserves and avoid statutory supervision by their use of the 2014 Opinion, participated in the preparation of financial information provided to Nevada DOI insurance regulators, and had subsequent communications with NHC and/or Nevada

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DOI insurance regulators, which they knew to be false and not in accordance with required statutory and professional standards.

414. The Milliman Defendants knew that their actions were inherently dangerous or posed a substantial risk of harm to others in that their actions could affect and disrupt the medical care of NHC's members and insured enrollees.

415. The Milliman Defendants' actions did affect and disrupt the medical care of NHC's members and enrolled insured.

416. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

417. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO MILLENNIUM DEFENDANTS

FIFTEENTH CAUSE OF ACTION

(Professional Malpractice Against Millennium)

418. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

419. Millennium was engaged by NHC and was responsible for providing professional accounting services to NHC.

420. Such services included, but were not limited to, preparing and filing the NHC Annual Reports, quarterly reports, and other reports as listed herein.

421. Services to be performed by Millennium included the preparation of financial statements, participating in the drafting of the year 2014 Management & Discussion and Analysis that was filed with the Nevada DOI insurance regulators, evaluating general ledger entries to ensure that statutory accounting and reporting principles and rules were followed, and recommending any adjustments to adhere to statutory accounting and reporting rules prescribed by the State of Nevada.

422. Millennium had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

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423. As detailed above, Millennium breached that duty by failing to comply with applicable statutory and professional standards.

424. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

425. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTEENTH CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against Millennium)

426. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

427. Throughout the time that Millennium performed services for NHC, Millennium represented that it was performing such services in accordance with applicable statutory, professional, and contractual standards.

428. Millennium knew or believed that its representations as stated above, were false, or Millennium had an insufficient basis of information for making such representations.

429. Plaintiff justifiably relied upon Millennium's representations.

430. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

431. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SEVENTEENTH CAUSE OF ACTION

(Negligent Misrepresentation Against Millennium)

432. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

433. Millennium, in the course of action in which it had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff, as set forth above.

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434. Such information included, without limitation, that the accounting services of Millennium were performed in accordance with applicable standards and that the information contained in the reports prepared by Millennium on NHC was accurate.

435. Plaintiff justifiably relied on the information it received.

436. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

437. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

EIGHTEENTH CAUSE OF ACTION

(Negligence Against Millennium)

438. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

439. Millennium owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable statutory and professional and contractual standards.

440. As detailed above, by failing to perform to applicable statutory, professional, and contractual standards, Millennium breached that duty.

441. The breach was the legal cause of Plaintiff's injuries.

442. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

443. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

NINETEENTH CAUSE OF ACTION

(Breach of Contract Against Millennium)

444. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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445. Millennium and NHC entered into a valid and enforceable contract - the January 7, 2015 Service Agreement - that required Millennium to perform professional accounting and consulting services.

446. Provisions of the Service Agreement provided for Millennium to perform all services in accordance with applicable professional, statutory, and contractual standards.

447. Millennium failed to perform accounting and consulting services as required under applicable professional, statutory and contractual standards.

448. Plaintiff performed or was excused from performance under the Services Agreement.

449. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

450. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against Millennium)

451. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

452. Millennium and NHC entered into a valid and enforceable contract - the January 7, 2015 Service Agreement - that required Millennium to perform professional accounting and consulting services.

453. Under applicable law, the Service Agreement contains an implied covenant of good faith and fair dealing among all parties.

454. A special element of reliance or fiduciary duty existed between Plaintiff and Millennium where Millennium was in a superior or trusted position.

455. In failing to perform in accordance with statutory and professional standards as set forth herein, Millennium breached the duty of good faith and engaged in misconduct in a manner that was unfaithful to the purpose of the Service Agreement.

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456. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

457. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against Millennium)

458. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

459. Millennium and NHC entered into a valid and enforceable contract - the January 7, 2015 Service Agreement - that required Millennium to perform professional accounting and consulting services.

460. Under applicable law, the Service Agreement contains an implied covenant of good faith and fair dealing among all parties.

461. Millennium, by failing to follow applicable professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Service Agreement.

462. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

463. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Millennium)

464. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

465. Millennium undertook to provide accounting and consulting services, including, but not limited to, preparing and filing financial statements on behalf of NHC.

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466. Such services included, but were not limited to, preparing and filing the NHC Annual Reports, quarterly reports, and other reports as listed herein, and it assisted with the preparation of the 2014 Management Discussion & Analysis that was reported to the Nevada DOI insurance regulators.

467. Services to be performed by Millennium also included evaluating general ledger entries to ensure that statutory accounting and reporting principles had been followed, and recommending any adjustments so as to adhere to statutory accounting and reporting rules prescribed by the State of Nevada.

468. Millennium knew or should have recognized these undertakings as being necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

469. By agreeing to perform the accounting and consulting services detailed above, Millennium undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators and to act in accordance with statutory and professional standards.

470. Millennium's failure to exercise reasonable care in performing its services, including Millennium's failure to perform accounting services in accordance with applicable standards as detailed herein and misreporting of financial information and reports, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada, and it unnecessarily prolonged, and it led to, the continued and unjustified existence of NHC.

471. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

472. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against Millennium)

473. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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474. Millennium was paid for accounting and consulting services that were to be performed in accordance with professional, statutory, and contractual standards.

475. Despite not providing such services in accordance with professional, statutory, and contractual standards, and against fundamental principles of justice, equity, and good conscience, Millennium unjustly retained the fees paid to it for such services.

476. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

477. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO LARSON DEFENDANTS

TWENTY-FOURTH CAUSE OF ACTION

(Negligence Per Se - Violation of NRS 628.435 Against Larson Defendants)

478. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

479. NRS 628.435 requires, in part, that a CPA comply with all professional standards for accounting and documentation related to an audit applicable to a particular engagement.

480. Plaintiff, and those represented by Plaintiff, including the members of NHC, NHC's insured enrollees, NHC's vendors, NHC, and the State of Nevada, belong to a class of persons that NRS 628.435 was designed to protect.

481. The Larson Defendants undertook to perform audits of NHC.

482. As a result, the Larson Defendants were subject to the minimum standards as set forth in NRS 628.435.

483. As set forth above, the Larson Defendants violated NRS 628.435 by failing to perform their duties as CPAs in accordance with the minimum statutory and applicable professional standards required.

484. Plaintiff's injury was the type against which NRS 628.435 was intended to protect.

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485. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

486. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-FIFTH CAUSE OF ACTION

(Professional Malpractice Against Larson Defendants)

487. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

488. The Larson Defendants were engaged by NHC or were responsible for providing professional accounting and auditing services to NHC.

489. Such services included but were not limited to auditing the books and records of NHC for the years ended December 31, 2013 and 2014 and its Management Discussion & Analysis for those years, and providing the audit opinions set forth in related reports, including the Audit Report Concerning NHC's December 31, 2014 and 2015 Financial Statements, The Reports of Independent Certified Public Accountants required by OMB Circular A-133, Independent Auditor's Report on Compliance for each Major Program, and Report on Internal Control Over Compliance Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards.

490. The Larson Defendants had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

491. As detailed above, the Larson Defendants breached that duty by failing to comply with applicable statutory and professional standards.

492. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

493. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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TWENTY-SIXTH CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against Larson Defendants)

494. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

495. On or about May 29, 2014, Larson issued its audit report concerning NHC's December 31, 2013 financial statements.

496. On or about June 1, 2015, Larson issued its audit report concerning NHC's December 31, 2014 and 2015 Financial Statements.

497. The audit reports contained the following statements:

a) We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States.

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

c) In our opinion, the statutory financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of Nevada Health Co-Op as of December 31, 2014, and 2013, and the results of its operations and its cash flow for the years then ended, in accordance with the financial reporting provisions of the Nevada DOI described in Note 1.

d) In our opinion, the [Supplementary] information is fairly stated in all material respects in relation to the financial statements taken as a whole.

498. On or about June 1, 2015, Larson issued its report entitled The Reports of Independent Certified Public Accountants required by OMB Circular A-133.

499. These reports included an "Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards," and an "Independent Auditor's Report on Compliance for each Major Program; Report on Internal Control Over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by OMB Circular A-133."

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500. The "Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards" contained the following statements:

a) We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the statutory financial statements of Nevada Health Co-Op (the Co-Op) (a nonprofit organization), which comprise the statement of financial position as of December 31, 2014, and the related statutory financial statements of activities, and cash flows for the year then ended, and the related notes to the statutory financial statements, and have issued our report thereon dated June 1, 2015.

b) ... during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses.

c) As part of obtaining reasonable assurance about whether the Co-Op's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts.

d) The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

501. The "Independent Auditor's Report on Compliance for each Major Program; Report on Internal Control Over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by OMB Circular A-133" contained the following statements:

a) We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program.

b) In our opinion, the Co-Op complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2014.

c) In planning and performing our audit of compliance, we considered the Co-Op's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an

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opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133.

d) We did not identify any deficiencies in internal control over compliance that we considered to be material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses.

e) We have audited the statutory financial statements of the Co-Op, as of and for the year ended December 3, 2014, and the related notes to the statutory financial statements. We issued our report thereon dated June 1, 2015, which contained an unmodified opinion on those statutory financial statements.

f) The [Schedule of Expenditures for Financial Awards] has been subjected to the auditing procedures applied in the audit of the statutory financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the statutory financial statements as a whole.

502. The Larson Defendants knew or believed that their representations as stated above, were false, or that the Larson Defendants had an insufficient basis of information for making the representations.

503. Plaintiff justifiably relied upon the Larson Defendants' representations.

504. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

505. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-SEVENTH CAUSE OF ACTION

(Negligent Misrepresentation Against Larson Defendants)

506. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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507. The Larson Defendants, in the course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff as set forth above.

508. Such information included, without limitation, that the accounting and auditing services of the Larson Defendants were performed in accordance with applicable standards and other information contained in the reports of the Larson Defendants on NHC, as set forth herein.

509. Plaintiff justifiably relied on this information it received.

510. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

511. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-EIGHTH CAUSE OF ACTION

(Negligence Against Larson Defendants)

512. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

513. The Larson Defendants owed a duty of care to Plaintiff, including the duty to perform their work in accordance with applicable statutory and professional standards.

514. As detailed above, by failing to perform to applicable statutory and professional standards, the Larson Defendants breached that duty.

515. The breach was the legal cause of Plaintiff's injuries.

516. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

517. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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TWENTY-NINTH CAUSE OF ACTION

(Breach of Contract Against Larson)

518. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

519. Larson and NHC entered into two valid and enforceable contracts - the 2013 and the 2014 Engagement Letters - that required Larson to perform professional accounting and auditing services.

520. Provisions of the Engagement Letters provided for Larson to perform all services in accordance with applicable professional standards.

521. Larson failed to perform under the Engagement Letters by failing to perform accounting and auditing services as required under applicable professional and statutory standards, as detailed above.

522. Plaintiff performed or was excused from performance under the Engagement Letters.

523. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

524. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against Larson)

525. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

526. Larson and NHC entered into two valid and enforceable contracts - the 2013 and the 2014 Engagement Letters - that required Defendant to perform professional accounting and auditing services.

527. Under applicable law, the Engagement Letters contain an implied covenant of good faith and fair dealing among all parties.

528. A special element of reliance or fiduciary duty existed between Plaintiff and Larson where Larson was in a superior or trusted position.

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529. Larson breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the Engagement Letters, by failing to perform in accordance with statutory and professional standards as set forth herein.

530. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

531. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against Larson)

532. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

533. Larson and NHC entered into two valid and enforceable contracts - the 2013 and the 2014 Engagement Letters - that required Defendant to perform professional accounting and auditing services.

534. Under applicable law, the Engagement Letters contain an implied covenant of good faith and fair dealing among all parties.

535. Larson, by failing to follow applicable professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Engagement Letters.

536. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

537. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Larson Defendants)

538. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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539. The Larson Defendants undertook to provide accounting and auditing services, including but not limited to examining the books and records of NHC.

540. Such services included but were not limited to auditing the books and records of NHC for the years ended December 31, 2013 and 2014 and its Management Discussion & Analysis for those years, and providing the audit opinions set forth in related reports, including the Audit Report concerning NHC's December 31, 2014 and 2015 Financial Statements, The Reports of Independent Certified Public Accountants required by OMB Circular A-133, Independent Auditor's Report on Compliance for each Major Program, and Report on Internal Control Over Compliance Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards.

541. The Larson Defendants knew or should have recognized these undertakings as necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

542. By performing the accounting and auditing services detailed above, the Larson Defendants undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators to act in accordance with statutory and professional standards.

543. The Larson Defendants' failure to exercise reasonable care in performing its services, including the Larson Defendants' failure to perform accounting and auditing services in accordance with applicable standards as detailed herein, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada.

544. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

545. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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THIRTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against Larson)

546. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

547. Larson was paid for accounting and auditing services that were to be performed in accordance with statutory and professional standards.

548. Despite failing to provide such services in accordance with statutory and professional standards, Larson unjustly retained the fees paid to it for such services against fundamental principles of justice, equity, and good conscience.

549. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

550. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO INSUREMONKEY DEFENDANTS

THIRTY-FOURTH CAUSE OF ACTION

(Intentional Misrepresentation/Fraud in the Inducement Against InsureMonkey Defendants)

551. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

552. From April through September 2013, InsureMonkey's officers, directors, and agents - including its CEO Rivlin - represented to NHC that they had the necessary skill, experience, and expertise to handle all aspects of the customer and members' services contemplated by the parties' potential agreements in a competent and professional manner.

553. Throughout the course of dealing with NHC, the InsureMonkey Defendants also misrepresented the number of customers obtained by InsureMonkey's marketing efforts and the number of insured enrollees in order to obtain additional fees and income that InsureMonkey had not earned.

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554. The InsureMonkey Defendants knew or believed that their representations were false, or the InsureMonkey Defendants had an insufficient basis of information for making the representation.

555. The InsureMonkey Defendants made such representations to induce NHC to enter into the various agreements listed herein with InsureMonkey related to member and customer services and so that CEO Rivlin could personally obtain exorbitant salaries, bonuses, and other remuneration for entering into the lucrative agreements with NHC.

556. NHC reasonably and justifiably relied upon the InsureMonkey Defendants' representations.

557. As a direct and proximate result of the InsureMonkey Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

558. In committing the acts herein above alleged, the InsureMonkey Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the InsureMonkey Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

559. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-FIFTH CAUSE OF ACTION

(Constructive Fraud Against InsureMonkey Defendants)

560. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

561. At all relevant times, a fiduciary duty existed between Plaintiff and the InsureMonkey Defendants, where the InsureMonkey Defendants were in a superior or trusted position as set forth herein.

562. The InsureMonkey Defendants owed a legal or equitable duty to NHC arising from a fiduciary or confidential relationship.

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563. The InsureMonkey Defendants breached that duty by misrepresenting or concealing material facts, i.e. that the InsureMonkey Defendants did not have the requisite skill, experience, or expertise to perform the services contemplated by the parties' agreements listed herein and that it failed to perform in a manner consistent with minimum industry standards as set forth herein.

564. The InsureMonkey Defendants also breached that duty by misrepresenting the number of customers obtained by InsureMonkey's marketing efforts and the number of insured enrollees in order to obtain additional fees and income InsureMonkey had not earned.

565. As a direct and proximate result of the InsureMonkey Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

566. In committing the acts herein above alleged, the InsureMonkey Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the InsureMonkey Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

567. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-SIXTH CAUSE OF ACTION

(Negligent Misrepresentation Against InsureMonkey Defendants)

568. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

569. The InsureMonkey Defendants, in the course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to NHC as set forth above.

570. Such information included, without limitation, the number of customers obtained by InsureMonkey's marketing efforts, the number of eligible enrollees, the eligibility data provided to NHC and/or CMS, and other reporting information provided to NHC or otherwise required by the parties' agreements or the CMS Loan Agreement.

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571. NHC reasonably and justifiably relied on the information it received from the InsureMonkey Defendants.

572. As a direct and proximate result of the InsureMonkey Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

573. In committing the acts herein above alleged, the InsureMonkey Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the InsureMonkey Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

574. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-SEVENTH CAUSE OF ACTION

(Breach of Fiduciary Duty Against InsureMonkey)

575. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

576. A fiduciary duty existed between NHC and InsureMonkey wherein InsureMonkey was in a superior or trusted position as set forth herein.

577. InsureMonkey breached that duty by failing to perform minimum professional standards and by otherwise providing misleading and inaccurate information as set forth above.

578. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

579. In committing the acts herein above alleged, InsureMonkey is guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from InsureMonkey for the purpose of deterring it and others similarly situated from engaging in like conduct in the future.

580. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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THIRTY-EIGHTH CAUSE OF ACTION

(Negligence Against InsureMonkey)

581. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

582. InsureMonkey owed a duty of care to NHC, including the duty to perform its work in accordance with industry standards and to not provide misleading or otherwise inaccurate information upon which it intended for and knew NHC would rely.

583. As detailed above, by failing to perform to applicable professional standards, InsureMonkey breached that duty.

584. The breach was the legal cause of NHC's injuries.

585. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

586. In committing the acts herein above alleged, InsureMonkey is guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from InsureMonkey for the purpose of deterring it and others similarly situated from engaging in like conduct in the future.

587. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-NINTH CAUSE OF ACTION

(Breach of Contract Against InsureMonkey)

588. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

589. InsureMonkey and NHC entered into a series of valid and enforceable contracts as set forth herein.

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590. InsureMonkey failed to perform under the various agreements as set forth herein, including, but not limited to, the 2013 Master Services Agreement, the 2013 Customer Service MOU, and the Master Agreement, by failing to provide the services contemplated therein in a reasonable and satisfactory manner, as detailed above.

591. NHC performed or was excused from performance with respect to all of the agreements set forth and detailed above. Such performance included paying InsureMonkey in excess of $9.4 million for services rendered.

592. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

593. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing Against InsureMonkey)

594. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

595. InsureMonkey and NHC entered into a series of valid and enforceable contracts as set forth herein.

596. InsureMonkey owed a duty of good faith to Plaintiff arising from such contracts.

597. A special element of reliance or fiduciary duty existed between Plaintiff and InsureMonkey wherein InsureMonkey was in a superior or trusted position.

598. InsureMonkey breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the agreements described herein, by failing to perform in accordance with basic, minimum professional standards as set forth herein, including, but not limited to, providing intentionally false and/or misleading and faulty sales, enrollment, and eligibility data, upon which it intended for NHC to rely.

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599. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

600. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against InsureMonkey)

601. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

602. InsureMonkey and NHC entered into a series of valid and enforceable contracts as set forth herein.

603. InsureMonkey owed a duty of good faith to Plaintiff arising from such contracts.

604. Under applicable law, these agreements contained an implied covenant of good faith and fair dealing among all parties.

605. InsureMonkey breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the agreements described herein, by failing to perform in accordance with basic, minimum professional standards as set forth herein, including, but not limited to, providing intentionally false and/or misleading and faulty sales, enrollment, and eligibility data, upon which it intended for NHC to rely.

606. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

607. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against InsureMonkey)

608. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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609. InsureMonkey undertook to provide certain services related to tracking and reporting enrollment and eligibility data on behalf of NHC, to provide that information to both NHC and CMS for purposes of calculating certain amounts owed by NHC, to be received by NHC, or for other purposes.

610. InsureMonkey knew or should have recognized that these undertakings were necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

611. By performing the services detailed above, InsureMonkey undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators to act in accordance with statutory and professional standards, and to properly track and report enrollment and eligibility data.

612. InsureMonkey's failure to exercise reasonable care in performing its services increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada.

613. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

614. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against InsureMonkey)

615. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

616. InsureMonkey was paid over $9.4 million for services that were to be performed in accordance with certain professional and industry standards.

617. Despite its failure to provide such services and/or not providing the quality of services required, InsureMonkey unjustly retained the fees paid to it for such services against fundamental principles of justice, equity, and good conscience.

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618. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

619. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-FOURTH CAUSE OF ACTION

(Negligent Hiring, Training, Supervision, and Retention Against InsureMonkey)

620. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

621. InsureMonkey owed a duty to exercise due care towards NHC in all of its dealings in providing the services contemplated by their various agreements, including, but not limited to, the Master Agreement.

622. InsureMonkey breached that duty by failing to provide services to satisfy minimum industry standards and practices.

623. InsureMonkey's failure to properly hire, train, and supervise its employees and agents to ensure that they acted in a competent and professional manner and with the requisite skill and expertise necessary to perform and complete the work was a direct and proximate cause of NHC's injuries as set forth herein.

624. InsureMonkey's decision to provide inadequate training and to hire and retain certain employees who were unsatisfactory and unable to fulfill InsureMonkey's obligations and responsibilities to NHC was the direct and proximate cause of NHC's injuries as set forth herein.

625. As detailed above, by failing to perform to applicable professional and industry standards, InsureMonkey breached that duty.

626. The breach was the legal cause of Plaintiff's injuries.

627. InsureMonkey knew or should have known that the employees and agents it had hired were unfit for their positions and would likely cause harm to third parties when placed in the positions in which InsureMonkey placed them.

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628. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

629. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO NHS

FORTY-FIFTH CAUSE OF ACTION

(Professional Malpractice Against NHS)

630. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

631. NHS was engaged by NHC and was responsible for providing professional medical utilization management and member eligibility review services to NHC.

632. Such services included, but were not limited to performing evaluations of appropriateness and medical necessity of heath care services, procedures and facilities; performing precertification of hospital admissions and outpatient procedures; processing information related to in-hospital observations; providing concurrent reviews for inpatient acute care, rehabilitation and long term acute care; providing discharge planning; performing provider appeal reviews; and performing member eligibility review, along with other services, as listed herein.

633. NHS had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

634. As detailed above, NHS breached that duty by failing to comply with applicable contractual, professional and industry standards.

635. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

636. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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FORTY-SIXTH CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against NHS)

637. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

638. Throughout the time that NHS performed services for NHC, NHS represented that it was performing such services, and that such services were being performed in accordance with applicable statutory, professional, and contractual standards.

639. NHS knew or believed that its representations as stated above, were false, or NHS had an insufficient basis of information for making such representations.

640. Plaintiff justifiably relied upon NHS's representations.

641. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

642. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-SEVENTH CAUSE OF ACTION

(Negligent Misrepresentation Against NHS)

643. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

644. NHS, in the course of action in which it had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff, as set forth above.

645. Such information included, without limitation, that the services of NHS were performed in accordance with applicable standards and that the information contained in the reports prepared by NHS was accurate.

646. Plaintiff justifiably relied on the information it received.

647. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

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648. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-EIGHTH CAUSE OF ACTION

(Negligence Against NHS)

649. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

650. NHS owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable statutory and professional and contractual standards.

651. As detailed above, by failing to perform to applicable statutory, professional, and contractual standards, NHS breached that duty.

652. The breach was the legal cause of Plaintiff's injuries.

653. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

654. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-NINTH CAUSE OF ACTION

(Breach of Contract Against NHS)

655. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

656. NHS and NHC entered into a valid and enforceable contract - the July 19, 2013 Utilization Management Services Agreement - that required NHS to perform professional medical utilization management and member eligibility review services.

657. Provisions of the Utilization Agreement provided for NHS to perform all services in accordance with applicable professional, statutory, and contractual standards.

658. NHS failed to perform accounting and consulting services as required under applicable professional, statutory and contractual standards.

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659. Plaintiff performed or was excused from performance under the Utilization Agreement.

660. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

661. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against NHS)

662. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

663. NHS and NHC entered into a valid and enforceable contract - the July 19, 2013 Utilization Management Services Agreement - that required NHS to perform professional medical utilization management and member eligibility review services.

664. Under applicable law, the Utilization Agreement contains an implied covenant of good faith and fair dealing among all parties.

665. A special element of reliance or fiduciary duty existed between Plaintiff and NHS where NHS was in a superior or trusted position.

666. In failing to perform in accordance with contractual, statutory and professional standards as set forth herein, NHS breached the duty of good faith and engaged in misconduct in a manner that was unfaithful to the purpose of the Service Agreement.

667. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

668. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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FIFTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against NHS)

669. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

670. NHS and NHC entered into a valid and enforceable contract - the July 19, 2013 Utilization Management Services Agreement - that required NHS to perform professional medical utilization management and member eligibility review services.

671. Under applicable law, the Utilization Agreement contains an implied covenant of good faith and fair dealing among all parties.

672. NHS, by failing to follow applicable contractual, professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Utilization Agreement.

673. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

674. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against NHS)

675. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

676. NHS undertook to provide medical utilization management and member eligibility review services.

677. Such services included, but were not limited to performing evaluations of appropriateness and medical necessity of heath care services, procedures and facilities; performing precertification of hospital admissions and outpatient procedures; processing information related to in-hospital observations; providing concurrent reviews for inpatient acute care, rehabilitation and long term acute care; providing discharge planning; performing provider appeal reviews; and performing member eligibility review, along with other services, as listed herein.

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678. NHS knew or should have recognized these undertakings as being necessary for the protection of NHC's members, NHC's enrolled insureds, NHC's creditors, and the State of Nevada.

679. By agreeing to perform the accounting and consulting services detailed above, NHS undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators and to act in accordance with statutory and professional standards.

680. NHS's failure to exercise reasonable care in performing its services, including NHS's failure to perform medical utilization management and member eligibility review services in accordance with applicable standards as detailed herein, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada, and it unnecessarily prolonged, and it led to, the continued and unjustified existence of NHC.

681. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

682. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against NHS)

683. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

684. NHS was paid for medical utilization management and member eligibility review services that were to be performed in accordance with professional, statutory, and contractual standards.

685. Despite not providing such services in accordance with professional, statutory, and contractual standards, and against fundamental principles of justice, equity, and good conscience, NHS unjustly retained the fees paid to it for such services.

686. NHS's compensation was mechanically calculated based on the total persons enrolled as NHC members each month, a fee that bore little to no relation to services being provided by NHS. Upon information and belief, little work was actually performed by NHS for NHC in relation to the substantial fees paid.

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687. Upon information and belief, UHH was the owner of NHS. UHH was being paid to process and adjudicate claims of NHC, and then it was being paid again through NHS to do a quality control review check of the very claims that UHH processed, which also resulted in NHC being unjustly compensated. NHS also had a conflict of interest, or the appearance of a conflict of interest, by being engaged to provide a quality control review of claim services provided by its parent company, UHH, resulting in unjust compensation to NHS.

688. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

689. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO MANAGEMENT DEFENDANTS

FIFTY-FOURTH CAUSE OF ACTION

(Breach of Fiduciary Duty Against Management Defendants)

690. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

691. As officers and directors of NHC, the Management Defendants, and each of them, owed duties of good faith and loyalty to act in the best interests of NHC.

692. Each of the Management Defendants breached his or her duties by failing to act in the bests interests of NHC and instead in their own self-serving interests as set forth above.

693. The breaches of fiduciary duties outlined herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

694. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

695. In committing the acts herein above alleged, the Management Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Management Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

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696. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-FIFTH CAUSE OF ACTION

(Intentional Misrepresentation/Fraud Against Management Defendants)

697. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

698. On February 28, 2015, and approximately mid-May 2015, the Management Defendants adopted and submitted the 2014 and March 2015 quarterly financial statements for NHC to the Nevada DOI insurance regulators. On or about April 1, 2015, the Management Defendants adopted and submitted a Management Discussion & Analysis that was submitted to the Nevada DOI insurance regulators as to the financial condition and prospective information of NHC.

699. On or about June 1, 2015, the Management Defendants adopted and authorized the release of the Audit Report prepared by Larson concerning NHC's December 31, 2014 and 2015 Financial Statements.

700. The financial statements, Management Discussion & Analysis, and Audit Report contained information that was false and misleading as set forth herein.

701. The Management Defendants knew or believed that their representations as stated above were false, or the Management Defendants had an insufficient basis of information for making the representations.

702. Plaintiff and those represented by Plaintiff justifiably relied upon the Management Defendants' representations contained in NHC's financial statements, Management Discussion & Analysis, and Audit Report.

703. As a direct and proximate result of the Management Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

704. In committing the acts herein above alleged, the Management Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Management Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

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705. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-SIXTH CAUSE OF ACTION

(Negligent Misrepresentation Against Management Defendants)

706. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

707. The Management Defendants, in the course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff as set forth above.

708. Such information included, without limitation, that the financial statements and Management Discussion & Analysis prepared, approved, ratified, or otherwise adopted by the Management Defendants were truthful, accurate, prepared, and performed in accordance with applicable standards.

709. Such representations involved negligence, intentional misconduct, fraud, and/or a knowing violation of the law.

710. Plaintiff justifiably relied on this information it received.

711. As a direct and proximate result of the Management Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

712. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-SEVENTH CAUSE OF ACTION

(Constructive Fraud Against Management Defendants)

713. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

714. At all relevant times, the Management Defendants had a fiduciary and/or confidential relationship with NHC based on the facts alleged herein.

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715. The Management Defendants owed a legal or equitable duty to NHC arising from a fiduciary or confidential relationship.

716. The Management Defendants breached that duty by misrepresenting or concealing material facts by preparing, disseminating, and authorizing unreliable and untruthful financial information and a Management Discussion & Analysis concerning NHC and its operations.

717. The Management Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

718. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

719. In committing the acts herein above alleged, the Management Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Management Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

720. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-EIGHTH CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Management Defendants)

721. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

722. The Management Defendants undertook to provide certain management and operational services to NHC, knowing that information would be used by NHC and provided to CMS for purposes of calculating certain amounts owed by NHC, to be received by NHC, or for other known purposes.

723. The Management Defendants knew or should have recognized these undertakings as necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

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724. By performing the services detailed above, the Management Defendants undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators to act in accordance with statutory and professional standards.

725. The Management Defendants' failure to exercise reasonable care in performing its services increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada.

726. The Management Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

727. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

728. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-NINTH CAUSE OF ACTION

(Unjust Enrichment Against Management Defendants)

729. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

730. Each of the Management Defendants was paid considerable and exorbitant amounts in compensation, including salary and bonuses without justification, and such compensation was paid despite the fact that NHC was losing millions of dollars each financial reporting period.

731. Management Defendants also engaged NHS to perform utilization review and management for claims and eligibility status in 2014, and NHC paid substantial fees to NHS for this service that also included NHS's overhead, out-of-pocket expenses, and taxes. Former Chief Executive Officer William Donahue claimed that he was unjustly pressured to sign the NHS engagement agreement. Upon information and belief, Management Director Defendant Kathleen Silver was President of NHS and UHH was its sole member, and Defendant Kathleen Silver engaged in self-dealing and was unjustly paid substantial amounts by NHS in this role, or she allowed UHH to be paid unjust amounts under this agreement. Upon information and belief, little

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work was provided by NHS for NHC, and NHS compensation was unfairly based on a mechanical fee of how many total members existed at NHC each month; a fee that bore little to no relation to services being provided. In 2014, in excess of $1 million in claims were paid outside of enrollment when NHS was required but failed to properly perform eligibility status for member claims, with approximately $382,968 paid to NHS for it so called utilization management and member eligibility review services.

732. Some of the Management Defendants' compensation was based upon the unreliable and untruthful financial information prepared by, approved by, and/or ratified by these Management Defendants, which amounts Management Defendants are continuing to hold in violation of equity and good conscience.

733. In light of the actions set forth herein, such amounts should be disgorged from the Management Defendants and returned to NHC in the interests of equity.

734. The Management Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

735. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

736. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTIETH CAUSE OF ACTION

(Negligent Hiring, Training, Supervision, and Retention Against Management Defendants)

737. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

738. The Management Defendants owed a duty to exercise due care towards NHC in all of its dealings, in providing management, operational, and supervisory services to NHC.

739. The Management Defendants breached their duty by failing to provide services to satisfy basic, minimum industry standards and practices with respect to hiring, training, supervising and retaining employees, agents, consultants, and vendors on behalf of NHC.

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740. The Management Defendants' failure to properly hire, train, and supervise its employees to ensure that its employees and agents acted in a competent and professional manner with the requisite skill and expertise necessary to perform and complete the work necessary to fulfill NHC's business was the direct and proximate cause of NHC's injuries, as set forth herein.

741. The Management Defendants' decisions to retain certain employees, agents, consultants, and vendors who were unsatisfactory and unable to fulfill the Management Defendants' obligations and responsibilities were the direct and proximate cause of NHC's injuries.

742. As detailed above, by failing to perform to applicable professional and industry standards, the Management Defendants breached that duty.

743. The Management Defendants' conduct involved intentional misconduct, fraud, and/or a knowing violation of the law.

744. These actions were the legal cause of Plaintiff's injuries.

745. The Management Defendants knew or should have known that the employees, agents, consultants, and vendors they had hired were unfit for their positions and would likely cause harm to third parties when placed in the positions in which the Management Defendants placed them.

746. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

747. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTY-FIRST CAUSE OF ACTION

(Breach of Contract Against Management Defendants)

748. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

749. Upon information and belief, each of the Management Defendants entered into enforceable agreements with NHC, including, but not limited to employment agreements and ethics and conflicts of interest agreements, which contractually provided for Management Defendants to operate in a fiduciary manner and to exercise the utmost good faith in all transactions involving their duties and to refrain from conflicts of interest, as set forth above.

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750. The Management Defendants failed to perform under such agreements as set forth above.

751. Plaintiff performed or was excused from performance under such agreements.

752. As a direct and proximate result of the Management Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

753. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO ALL DEFENDANTS

SIXTY-SECOND CAUSE OF ACTION

(Civil Conspiracy Against All Defendants)

754. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

755. Defendants acted in concert with each other and with certain of NHC's management and vendors, including, but not limited to, Milliman, Millennium, Larson, and InsureMonkey, to falsify operating results and reserves, to conceal internal control weaknesses and other wrongdoing, and to avoid statutory supervision by their use of untruthful and/or unreliable financial data and other information they knew to be false and not in accordance with required statutory and professional standards in order to continue the flow of money to NHC, and subsequently, to the Management Defendants and NHC's vendors for their own personal gain.

756. Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

757. Each of the Defendants are jointly and severally liable for the damages described herein.

758. As a direct and proximate result of Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

759. In committing the acts herein above alleged, Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

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760. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTY-THIRD CAUSE OF ACTION

(Concert of Action Against All Defendants)

761. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

762. Defendants acted in concert with each other and with certain of NHC's management and vendors, including, but not limited to, Milliman, Millennium, Larson, and InsureMonkey, to falsify operating results and reserves, to conceal internal control weaknesses and other wrongdoing, and to avoid statutory supervision by their use of untruthful and/or unreliable financial data and other information they knew to be false and not in accordance with required statutory and professional standards in order to continue the flow of money to NHC, and subsequently, to the Management Defendants and NHC's vendors for their own personal gain.

763. Defendants knew that their actions were inherently dangerous or posed a substantial risk of harm to others in that their actions could affect and disrupt the medical care of NHC's members and insured enrollees.

764. Defendants' actions did affect and disrupt the medical care of NHC's members and enrolled insureds.

765. The conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

766. Each of the Defendants are jointly and severally liable for the damages described herein.

767. As a direct and proximate result of Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

768. In committing the acts herein above alleged, Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

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769. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for relief in favor of Plaintiff and against each of the Defendants, as follows:

1. For damages in an amount in excess of fifteen thousand dollars ($15,000);

2. For prejudgment and post-judgment interest;

3. For all attorneys' fees and costs of suit; and

4. For such other and further relief as this Court may deem just and proper.

DATED this 25th day of August, 2017.

GREENBERG TRAURIG, LLP

/s/ Mark E. Ferrario, Esq.
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TAB 14

TAB 14

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Counsel for Barbara D. Richardson, Commissioner of Insurance, as the Permanent Receiver for Nevada Health CO-OP

IN THE EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER, Plaintiff, vs. NEVADA HEALTH CO-OP, Defendant.	Case No. A-15-725244-C Dept. No. 1

EIGHTH STATUS REPORT

COME NOW, Commissioner of Insurance Barbara D. Richardson in her capacity as Receiver of Nevada Health CO-OP ("NHC," or the "CO-OP"), and CANTILO & BENNETT, L.L.P., Special Deputy Receiver ("SDR" - SDR and the Commissioner as Receiver are referred to collectively herein as "Receiver"), and file this Eighth Status Report in the above-captioned receivership.

I. INTRODUCTION AND HISTORICAL BACKGROUND

The CO-OP is a state-licensed health insurer, formed in 2012 as a Health Maintenance Organization ("HMO"), with a Certificate of Authority granted by the State of Nevada Division of Insurance effective January 2, 2013. NHC is an Internal Revenue Code 501(c)(29) Qualified Non-Profit Health Insurance Issuer, entitled to tax exemption by the Internal Revenue Service. NHC was formed under a provision of the Patient Protection and Affordable Care Act ("ACA") providing for the formation of Consumer Operated and Oriented Plans. Having received from the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services ("HHS") a start-up loan of $17,080,047, and a "solvency" loan of $48,820,349, NHC was required to operate as a non-profit, consumer-driven health insurance issuer for the benefit of the public. The CO-OP's primary business was to provide ACA-compliant health coverage to residents of Nevada, and it operated its business for the benefit of Nevadans within the state, save for certain arrangements to provide nationwide health coverage to Nevadans traveling outside the state in certain circumstances. NHC began selling products on and off the Silver State Health Insurance Exchange (the "Exchange") on January 1, 2014. Its products include individual, small group, and large group managed care coverages.

On October 1, 2015, this Court issued its Order Appointing the Acting Insurance Commissioner, Amy L. Parks as Temporary Receiver of NHC Pending Further Orders of the Court and Granting Temporary Injunctive Relief Pursuant to NRS 696B.270 (the "Temporary Receivership Order"). Further, on October 14, 2015, the Receivership Court entered its Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health CO-OP (the "Permanent Receivership Order"), appointing the law firm of CANTILO & BENNETT, L.L.P. as SDR of NHC, in accordance with Chapter 696B of the Nevada Revised Statutes.

Via a Notice of Substitution of Receiver dated April 6, 2016, Ms. Joanna N. Grigoriev informed interested parties of the substitution of Commissioner Barbara D. Richardson, in place and stead of former Acting Commissioner Amy L. Parks, as the Receiver of NHC. This

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substitution of Receiver was subsequent to Commissioner Richardson's appointment as Commissioner of Insurance for the State of Nevada.

This Court, through its Final Order Finding and Declaring Nevada Health CO-OP to be Insolvent and Placing Nevada Health CO-OP into Liquidation (the "Final Order") dated September 20, 2016, adjudged NHC to be insolvent on grounds that it is unable to meet obligations as they mature. The Final Order also authorized the Receiver to liquidate the business of NHC and wind up its ceased operations pursuant to applicable Nevada law. The Receiver has since transitioned the receivership estate from rehabilitation to liquidation.

The Receiver continues to file quarterly status reports as ordered by this Court.

II. RECEIVERSHIP ADMINISTRATION

Receivership Administrative Services and Oversight

CANTILO & BENNETT, L.L.P., as SDR of NHC, manages the receivership estate and conducts its affairs. PALOMAR FINANCIAL, LC ("Palomar"), an affiliate of the SDR, performs administration, information technology, and other related services for the Receiver under the supervision of the SDR. The Receiver has included an informational copy, as Exhibit 1 to this Eighth Status Report, of the invoices paid to the SDR and Palomar since the last status report to this Court.

Resolution of Outstanding Receivership Matters

Pre-Liquidation Claims Adjudications and Data Inaccuracy Resolution

NHC's staff continues the process of claims adjudications to adjudicate all new and pending healthcare claims. At this point, new claims are only accepted for review if the claimant can show proof of timely filing (*i.e.,* proof that the claim was previously submitted in advance of the Receiver's Claims Filing Deadline). Additionally, NHC's staff also continues to correct what inaccuracies remain in NHC's enrollment databases, this project being ongoing throughout the pendency of the receivership. This enrollment evaluation is necessary to determine dates of coverage for each member's medical care. The final evaluation of enrollment information will also reconcile NHC's obligations to pay for member health care.

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The Receiver continues to coordinate with those plan members who were reported to collection agencies by healthcare providers and facilities, or who are currently being sought for payment based on the receivership estate's obligations. In cases where collection efforts have taken place in violation of the Permanent Receivership Order, NHC staff members contact those providers and any related collection agencies to inform them of the Permanent Receivership Order and its moratorium on the payment of health claims. When necessary, the SDR has also sent letters to such providers to advise them that their direct collection actions violate the Permanent Receivership Order, and may justify the equitable subordination of claims by providers who openly seek payment in violation of the priority scheme set forth in Chapter 696B of the Nevada Revised Statutes.

Continuation of Mandatory Regulatory Reporting to CMS

As explained in prior status reports, the Receiver and SDR continue to coordinate with CMS in the submission of essential data for the various regulatory reporting processes required for CO-OPs under the ACA. There are still ongoing requirements that NHC must fulfill, and significant accounts payable are in dispute. Resolution of these matters is critical to NHC's ability to claim and collect the maximum amounts rightfully owed to NHC under the various federal receivables programs.

NHC is owed payments relating to several such programs, including: Cost Sharing Reduction ("CSR") Reconciliation, Federal Transitional Reinsurance, Risk Adjustment, and Risk Corridors. The expected receipt of these federal receivables is a key part of any future claim payments by NHC. The non-receipt of substantially all federal accounts payable for plan year 2015, and a material portion of accounts payable for plan year 2014, has greatly diminished NHC's assets and, therefore, its claims-paying ability.

CMS has maintained the position that any monies deemed owed to NHC (*i.e.,* the receivership estate) are to be set off against the amounts CMS asserts it is owed under the start-up loan to NHC. CMS has so far made offsets against accounts payable to NHC for the outstanding balance of the start-up loan. These actions are the subject of the Receiver's complaint against CMS, as described in more detail below. In attempting to determine a total

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of all offsets applied by CMS to date, the SDR has determined certain discrepancies in CMS' accounting. The SDR sent a letter to CMS to request a detailed, cumulative accounting of all offsets applied to date so that the SDR can review CMS' accounting of charges and offsets applied to NHC's accounts payable.

Updates as to Current Status of Regulatory Submissions Projects

NHC Risk Adjustment and Federal Transitional Reinsurance data was submitted to CMS on May 2, 2016. On June 30, 2016, CMS released its Summary Report on Transactional Reinsurance and Permanent Risk Adjustment Transfers for the 2015 Benefit Year.[1] Per the report, for coverage year 2015, the CO-OP is owed a Federal Transitional Reinsurance payment of $8,842,009.69 and net Risk Adjustment transfer of $4,532,560.29. The 2015 Federal Transitional Reinsurance payment amount increased by $4,601.65 to $8,846,611.34 in the December 6, 2016, Amendment to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year.[2]

In 2016, the reporting related to the CSR Reconciliation program resulted in a net amount owed by NHC to CMS of $3,579,359.65 for 2014 and 2015 CSRs. At the beginning of June 2017, the SDR submitted amended filings to CMS of the 2014 and 2015 CSRs, resulting in NHC owing an adjusted balance to CMS of $482,948.54 rather than $3,579,359.65—or a reduction in NHC liability of $3,096,411.11.

The 2015 Risk Corridors data submissions were reported by the deadline of August 1, 2016. CMS originally requested a small restatement to one line item in NHC's submission, which would have had a small impact upon the amount owed to NHC. However, CMS then directed NHC not to make any restatement(s) of the 2015 Risk Corridors or Medical Loss Ratio ("MLR") data in 2016. Instead, CMS advised that a restatement of Risk Corridors and MLR data may be filed in 2017.

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[1] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf.

[2] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/DDC_RevisedJune30thReport_v2_5CR_120516.pdf.

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In regard to the final amount for the 2015 Risk Corridors, CMS confirmed that NHC is owed $29.9 million for its individual market and $3.75M for its small group market.[3] CMS has previously announced that, based on its preliminary analysis, ". . . all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments."[4] In addition to balances due for year 2015, the CO-OP is still owed over $9.5 million for 2014 Risk Corridors payments.[5] CMS stated in its November 18, 2016, Risk Corridors report that the expected payment towards NHC's 2014 Risk Corridors amounts is only $355,443.99.

NHC has made monthly submissions of Advance Premium Tax Credit ("APTC") billing data in accordance with CMS reporting requirements. The total of APTC payments received from CMS is substantially less than what NHC billed CMS for 2015 APTC, and the SDR has asserted a claim for the shortfall. CMS and NHC currently do not agree on the APTC balance due for year 2015. The SDR has sent a letter to CMS to request clarification and an accounting of its position on the 2015 APTC balance due to NHC.

Use of Third-Party Contractors as Part of Business Operations

The Receiver utilizes the services of several third-party contractors that had been engaged before commencement of the receivership, and some of them were engaged after the receivership commenced to assist in management of NHC's affairs.

The following is a list of independent contractors currently assisting the receivership:

1. Eldorado, a division of Mphasis Corporation, to provide a hosting service for claims data and information.

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[3] DEP'T OF HEALTH & HUMAN SERVICES & CENTERS FOR MEDICARE & MEDICAID SERVICES, CCIIO MEMORANDUM, RISK CORRIDORS PAYMENT AND CHARGE AMOUNTS FOR THE 2015 BENEFIT YEAR (November 18, 2016) (available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf).

[4] DEP'T OF HEALTH & HUMAN SERVICES & CENTERS FOR MEDICARE & MEDICAID SERVICES, CCIIO MEMORANDUM, Risk Corridors Payments for 2015 (September 9, 2016) (available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF).

[5] DEP'T OF HEALTH & HUMAN SERVICES & CENTERS FOR MEDICARE & MEDICAID SERVICES, CCIIO MEMORANDUM, RISK CORRIDORS PAYMENT AND CHARGE AMOUNTS FOR BENEFIT YEAR 2014 (1, Table 29) (November 19, 2015) (stating CMS' need to decrease, or "prorate," amounts owed to issuers due to budget shortfall, providing amounts owed to each issuer) (available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf).

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2. The Jacobson Group, to provide claims adjustment and customer service staffing support.

3. Redcard, to perform check processing and delivery to health care providers, and delivery of Explanation of Benefit disclosures to providers and plan members.

4. ADP, to provide payroll support and processing for employee compensation and benefits.

Internal Administrative Matters Related to Wind Down

NHC maintains staff to address calls from interested parties regarding the proof of claim ("POC") process, other claim matters, and the collection of assets for the receivership. The Receiver also continues to determine and refund premium overpayments to members since such overpayments were not funds to which NHC was entitled and are therefore outside the normal claim process. The estate expects to receive essentially no new requests for premium refunds as of the beginning of the fourth quarter of 2017, the SDR having returned premium overpayments upon request to members since January 1, 2016.

The wind down of NHC's 401(k) retirement plan continues, with the SDR having submitted to the Internal Revenue Service the Form 5310 for the retirement plan wind down. The Form 5310 filing sought a tax determination letter that would permit the distribution of 401(k) assets to employees without the need for an expensive and time-consuming audit. On September 21, 2017, the SDR received notice from the IRS via a letter dated September 14, 2017, that the termination of the 401(k) "doesn't affect its qualification for federal tax purposes." This favorable determination having been obtained, the SDR has instructed its 401(k) third-party administrator to begin the final processing of plan documents necessary for wind down, making sure that all employee terminations which occurred within and subsequent to 2015 be treated as events which vest 401(k) participants fully in the amounts held on their accounts.

The Receiver also maintains an office for NHC's essential office staff.[6]

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[6] Currently, NHC maintains fifteen full-time and two part-time employees.

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Authorization from this Court to Hire Consultants for Various Purposes

Previously, the Receiver filed a Motion to Approve Professional Fee Rates on an Order Shortening Time, seeking from this Court the approval of the professional fee rates for certain service providers deemed essential to receivership operations, as well as authorization for the Receiver to include paid invoices with quarterly status reports to this Court. Following a hearing which took place on January 10, 2017, this Court did enter an Order dated January 17, 2017, which approved that Motion in all relevant respects. The Receiver has been working with these professional firms regarding the receivership's affairs.

Motion for Electronically-Stored Information ("ESI") Filed with the Court

On June 20, 2017, Counsel for the Receiver filed with this Court a "Motion for Instructions for ESI Protocol and Protective Order," regarding management of electronically stored information and protection from disclosure of private healthcare information. The ESI Protocol governs how records are stored, provided, and protected in any current or future receivership litigation. Prior a hearing concerning that motion, this Court in a minute order requested clarification of certain legal authorities, as well as those documents described in Exhibit 2 of that motion. Such clarification was provided to the Court via a supplemental memorandum filed on August 28, 2017. Following a hearing which took place on September 5, 2017, this Court entered its Order Granting Receiver's Motion for Instructions for ESI Protocol and Protective Order, dated September 13, 2017, which approved the motion in all respects.

Commencement of Action Against Various Professionals and Other Firms Who Performed Services for and on Behalf of NHC

On August 25, 2017, Counsel for the Receiver filed in Clark County District Court a complaint (Case No. A-17-760558-C in Department No. 18) against various persons, third-party vendors, and professional service firms which are alleged to have contributed to NHC's current hazardous financial condition by, among other things, failing to adhere to applicable standards of professional care and requirements imposed by law, misrepresentation

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concerning quality and standard of care for services performed, and breaches of contract, duty, and implied covenants of good faith and fair dealing.

The complaint names, among others, NHC's former actuaries, accountants, auditors, and providers of certain business operations and utilization review services, as well as those individuals who specifically performed, or who were in the role of supervising the performance of, those services. The Complaint also names several of NHC's former directors and executive management. Formal answers have not yet been filed in that case.

On September 14, 2017, Counsel for the Receiver filed with this Court a Motion to Coordinate Cases, seeking a coordination of that case and the overarching receivership action being supervised by this Court on grounds that the case constitutes an asset recovery action, an integral part of the resolution of the receivership that merits continued supervision by this Court. This motion is set for in chambers hearing on October 19, 2017.

Commencement of Action Against CMS to Settle Questions of Setoff as to Mutual Obligations

On March 16, 2017, Counsel for the Receiver filed in the United States District Court for the District of Nevada a Complaint and Demand for Jury Trial (the "Complaint") against the United States Department of Health and Human Services, the Centers for Medicare and Medicaid Services, Thomas E. Price, M.D. in his capacity as the U.S. Secretary of Health and Human Services, and the United States (the "Defendants"). Through this Complaint, the Receiver seeks both judicial review of a final agency action made by Defendants and a declaratory judgment as to Defendants' right to set off any monies claimed against NHC through funds that HHS/CMS is statutorily obligated to pay to NHC. As has been reported to this Court on several occasions, Defendants (via CMS) have provided notice to the Receiver of their termination of the underlying Loan Agreement through which the CO-OP received funds under the ACA, declaring those loans immediately due and payable. Further, on March 6, 2016, HHS/CMS stated that an "administrative hold" on payables due to NHC had been implemented at the request of the U.S. Department of Justice. As part of this chain of events, on September 29, 2016, HHS/CMS claimed that approximately $7 million had been offset

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against funds payable to NHC from the outstanding amount of the start-up loan, and prospectively asserted its "right" to offset future payables. As noted above, CMS has since notified the SDR on several occasions of additional offsets, and the SDR has determined certain discrepancies in CMS' accounting. Consequently, the SDR has requested, in writing, that CMS provide a cumulative accounting of all offsets and charges applied to NHC's accounts payable to date.

The Complaint therefore seeks relief in the form of a declaratory judgment which holds that the federal government's setoffs and prospective setoffs are unlawful under Nevada state reserve requirements, solvency regulations, requisite surplus note requirements, and other similar laws. As well, the Receiver seeks a declaration that both the start-up and solvency loans given to NHC are subordinated to the claims of NHC's policyholders and subscriber members, that the debts the Defendants seek to set off lack the requirement of mutuality necessary to permit such a setoff, and that any such setoffs were and are improper.

Defendants' Motion to Dismiss was filed in that case on June 29, 2017, asserting that the Receiver's claim for declaratory relief fails both for lack of jurisdiction and on the merits.

A Stipulation and Order to Extend Briefing Schedule regarding that Motion to Dismiss was filed with the United States District Court for the State of Nevada, with the consent of counsel for both plaintiff and defendants, on August 8, 2017. This stipulation provides that the Receiver shall have up to and including August 28, 2017, to respond to HHS/CMS' motion to dismiss, and HHS/CMS shall have up to and including October 4, 2017, to submit a reply brief. This Stipulation was approved via an order entered August 10, 2017.

Following a motion seeking (and order approving) permission to file a pleading which extends beyond the page limits provided for in the applicable court rules, the Receiver filed her Opposition to Motion to Dismiss on August 28, 2017.

On October 4, 2017, the Defendants submitted their reply in support of the Motion to Dismiss. Oral argument on that motion is anticipated, but a hearing has not yet been scheduled.

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Notice of Claim Determination to CMS

In response to a POC filed by CMS against the NHC receivership estate before expiration of the April 28, 2017, claims filing deadline, a notice of claim determination ("NCD") was issued by the SDR to CMS on June 14, 2017, making the following claim determinations:

a. CMS claims have priority no higher than NRS § 696B.420(1)(d) ("Class D").

b. Federal law, including 31 U.S.C. § 3713, does not give CMS a claim priority higher than Class D with respect to NHC's assets or in the NHC liquidation proceeding.

c. Under federal and state law, including NRS 696B.440, CMS claims may not be properly set off "against debts owed to NHC by the United States."

d. Any setoff of amounts claimed by the U.S., if set off against amounts owed to NHC, would impermissibly elevate the U.S. claims above their statutory priority level.

e. Any setoff of amounts claimed by the U.S., if set off against amounts owed to NHC, would violate the NHC permanent receivership order.

f. The CMS claims are not entitled to secured creditor claim priority to the extent they are subject to a set off by a claim of NHC against the United States.

g. It appears that the receivership estate has insufficient assets to pay NHC claims with priority lower than Class B. Thus, the Receiver makes no determination right now as to the following: (1) the merit of the CMS claim, (2) the amount claimed, or (3) whether the CMS claim would have a Class D or lower priority.

h. No claim received after the NHC claims deadline, if not rendered absolute, is allowed to participate in a share of NHC's assets. Thus, any later or additional claim by CMS will be deemed a late-filed claim for which NHC is not liable. The purported claim reservation of the United States to assert later determined claims is therefore ineffective.

CMS was notified in the June 14, 2017, NCD that its appeal, if any, was due to be filed within sixty (60) days of the notice (*i.e.,* by August 13, 2017). To date, CMS has not provided

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any responsive appeal. Therefore, pursuant to the Receivership Appeal Procedure ("RAP"), the SDR's June 14, 2017, determination is final and non-appealable.

Filing in Small Claims Court by Former Member

NHC was made party to an action in the Justice Court for Las Vegas Township via an April 17, 2017, small claims complaint filed by a former member, Mr. Yiming Wu, regarding $4,727.74 that he claims he is owed by NHC for the CO-OP's allegedly reporting to the IRS incorrect information concerning his coverage, resulting in the assessment of a penalty. The complainant was advised via a letter from the receivership dated April 24, 2017, of the necessity of filing a POC against the CO-OP to protect his rights against estate assets, but to date such a POC has not been received. Counsel for the Receiver had filed a Motion to Dismiss on jurisdictional grounds, among others, asserting that this action must be before the Receivership Court to the exclusion of any other forum. Via an Order to Transfer Case filed September 13, 2017, the Las Vegas Justice Court transferred the case to the Receivership Court for further proceedings.

IRS Penalties Assessed for Data Inaccuracies in Information Filings

Via a notice dated October 2, 2017, the IRS made clear to the CO-OP its intention to seize and levy NHC's property in order to compel the payment of certain penalties assessed against NHC in connection with the CO-OP's submission of Form 1099 and Tax Information Number data deemed erroneous. That notice of intention to seize and levy concerns approximately $12,000 in penalties assessed for tax year 2014, but the IRS has also given notice to the receivership, via a notice dated August 21, 2017, of their proposed penalty of approximately $36,000 for similar data inaccuracies related to tax year 2015.

The Receiver is currently evaluating the nature of the IRS' proposed penalties and intent to seize and levy, with particular attention to any priority issues concerning the IRS claim. The Receiver has responded to this most recent penalty for tax year 2015, as she had responded to the IRS for the tax year 2014 penalty last year. The Receiver has explained to the IRS that reasonable cause to withhold the penalty exists in the case of NHC's receivership, both due to the ongoing hazardous financial condition of the company, and due

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to the existence of Treasury regulations which insulate assets administered by a receivership court from seizure and levy by the IRS.

Post-Receivership Hardship Claim Payments Made by the Receiver of NHC

The Receiver has thus far paid approximately $8.4 million in hardship claim payments to different health care providers or members for necessary pharmacological, psychological, and health care services. These hardship claim payments to providers and/or members concerned emergency services, vital prescription medicines, protection against instances of balance billing, and medical or financial hardships. The SDR continues to utilize the procedure developed and provided alongside the Fourth Status Report to adjudicate and process these payments. The Receiver will allow hardship claim payments to continue pursuant to this Court's prior order.[7]

Post-Receivership Non-Hardship Claim Payments to be Made by the Receiver of NHC

Certain members and other providers have contacted receivership staff to inquire as to when non-hardship claim payments will be made, and when the suspension on claims and other general creditor payments will be lifted. There are two reasons why non-hardship claim payments were suspended and delayed from being paid by NHC. Both these reasons were because of CMS actions and delays that have had a substantial and harmful impact on NHC's ability to pay claims. The Receiver of NHC would be paying non-hardship claim payments (as currently authorized—or as may be further authorized by this Court) if it were not for CMS actions.

Reason Number 1 for Suspension and Claims Payment Delay

NHC received approximately $65.9 million of loans from CMS before receivership as funds for the start-up and solvency as a health insurer. After receivership began, CMS demanded loan repayment and asserted that such repayment was legally entitled to a super-priority so that it had to be made before payment of any other claims against NHC other than

[7] On February 24, 2016, this Court entered its Order Granting Special Deputy Receiver, CANTILO & BENNETT, L.L.P.'s First Motion, on Order Shortening Time, for Order Authorizing Payments, and this Court Order authorized hardship claim payments by the Special Deputy Receiver.

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costs of administration. The Receiver tried without success to resolve this super-priority issue with CMS and the United States Department of Justice. As a further development to address the super-priority issue, an NCD was issued by the SDR to CMS on June 14, 2017, which denied the government's claim for super-priority. The government did not appeal the SDR's NCD, and the deadline for any appeal by the government has now expired.

Reason Number 2 for Suspension and Claims Payment Delay

CMS placed "an administrative hold" on all reimbursements due NHC under the federal receivables programs. The CMS reimbursements due NHC are in the tens of millions. Approximately $56 million is due from CMS and the federal government for federal receivables, not including APTC amounts that are currently in dispute between CMS and NHC. NHC's unpaid claim liabilities are also in the tens of millions, so federal receivables from CMS are essential to the ability of the Receiver to make meaningful claim payments. According to CMS, it placed the hold on federal receivable reimbursements due NHC due to nonpayment of the above-mentioned loans that are now claimed due by CMS. As a further development to address the administrative hold of the federal government, an NCD was issued by the SDR to CMS on June 14, 2017, which denied the government's claim for setoff. The government did not appeal the SDR's NCD, and the deadline for any appeal by the government has now expired. In addition, as described herein, the Receiver has filed the Complaint against HHS/CMS in which the Receiver seeks both judicial review of a final agency action made by HHS/CMS and a declaratory judgment as to HHS/CMS' right to set off any monies claimed against NHC through funds that HHS/CMS is statutorily obligated to pay to NHC.

Resolution of POCs, Provision of NCDs, Appeals

The Receiver has implemented the POC process approved by this Court in its Final Order, and has already conducted general mailings and publication of necessary notices to claimants and other interested parties.

The Claims Filing Deadline was April 28, 2017, and the SDR received 141 POCs. Many of these are incomplete or unable to be adjudicated for various other reasons, and the

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SDR has notified various claimants of claim deficiencies. The SDR will continue adjudicating POCs and developing NCDs in expectation of mailing such determinations after obtaining the necessary approval from this Court.

Claims for Which There Are Currently Insufficient Assets to Pay

It does not appear at this time that there will be sufficient assets to pay claims beyond those assigned a Class B priority pursuant to NRS 696B.420(1)(b). The SDR has received several POCs that should be assigned to priority classes C through L, pursuant to NRS 696B.420(1)(c)-(l). In such instances, the SDR proposes to send claimants NCDs that determine the priority of their claims, which determination will be subject to appeal under the Receivership Appeal Procedure ("RAP"). In order to conserve the assets of the estate, and per NRS696B.330(4), the SDR of NHC will refrain from reaching the merits of these claims until such time it appears that assets will be available for distribution to that class. If additional assets later become available for distribution to these claimants, the SDR will make a second claim determination as to the merits of each claim and notify the claimants of such determination.

Claims Asserted Against the Estate by Providers

Health care providers are not required to use the POC form to submit their claims, because NHC already has a pre-existing process for receiving and processing such claims, having thousands of such processed claims already in its claim processing system. Providers were required to use (and most did use) the pre-existing claims process to submit their claims before the Claims Filing Deadline.

The SDR will be preparing NCDs to send providers for their claims. After reporting claim determinations to the Court, the SDR will begin mailing providers' NCDs. The provider NCD will show the amount the SDR has approved to be paid for each claim, along with the member's responsibility portion of the claim—which the provider may collect from the member without violating the Permanent Receivership Order. For this reason, the member will also receive a copy of the NCD. Members and providers may appeal NCDs in accordance with the RAP.

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Xerox Notification of Short-Payments and Overpayments

Counsel for Xerox, in the matter of Basich v. Xerox, et al. (Case No. A-14-698567-C, filed with Department No. 4 in the Clark County District Court - litigation related to the operation and development of the Nevada Silver State Health Insurance Exchange (the "Exchange")) wrote to the Special Deputy Receiver on June 14, 2017, regarding "short-pay funds" that it claims "represents payment NHC consumers submitted to Xerox for the 2014 coverage year that were less than that consumer's [sic] full premium payment required to initiate transfer of the payment to NHC." Xerox went on to state that "Initially the Exchange was to receive these funds and apply the same to the corresponding consumer's account. However, the Exchange has declined to apply these funds to accounts currently held with the Exchange and instructed Xerox to remit those funds to the corresponding carrier." Included with the letter was a check for $25,616.44 to NHC for amounts that presumably should be refunded to certain consumers for the "short-pay funds." NHC has asked for further clarification and documentation from Xerox.

Also within the June 14, 2017, letter, Xerox states that NHC must refund certain other members for overpaid premiums that NHC received from Xerox during the 2014 coverage year. NHC is also evaluating the information necessary to refund overpayment amounts that may be due NHC's members.

Current Receivership Assets

The Receiver's evaluation of the assets and liabilities of the CO-OP is ongoing, and adjusted periodically to accommodate new authorized payments, receipts, and transfers. Below is an overview of some key asset matters thus far identified by the Receiver (other than those already mentioned herein):

1. Before year-end 2016, the Receiver submitted a reinsurance claim to Partner Re based on 2015 claims information. In April and May 2017, Partner Re paid the Receiver a total of $787,352.41 in satisfaction of NHC's reinsurance claims. The Receiver has submitted updated information to Partner Re, and it appears that a small return balance of $2,196.11 may be due Partner Re after a reconciliation of this updated information. The Receiver will

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submit further claims to Partner Re if the attachment point of reinsurance coverage is reached in the future.

2. The unrestricted cash assets of the CO-OP have fluctuated with post-receivership expenses and claim payments, as well as with the Receiver's receipt of member premiums. The currently-available, unrestricted cash assets of the CO-OP as of September 30, 2017, were approximately $7,552,983. The majority of NHC's currently available and liquid assets have been invested in a short-term bond mutual fund, with the remainder of such assets held in bank deposits. This amount considers the entire amount in once-restricted cash assets formerly held in a statutory special deposit account for the benefit of NHC's creditors, but which were released by this Court's order.

3. The financial information of NHC in this Eighth Status Report provides estimates. NHC's financials may materially vary depending upon the estate's receipt of the promised federal receivables payments under the various ACA programs described in this report and future litigation recoverables. These figures will remain estimates until the estate receives clearer indications from CMS and the federal government as to the amount and timing of any federal payments, as well as the outcome of the recent lawsuit filed by the Receiver against CMS regarding the administrative hold and asserted rights to setoff. As mentioned, the Receiver continues work to resolve matters with CMS.

4. The Receiver is enclosing, as Exhibit 2 attached hereto, a cash flow report for NHC for the period covering the inception of the receivership through September 30. 2017. This report reflects a summary of disbursements and collections made by NHC during this period.

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CONCLUSION

The Receiver has submitted this report in compliance with the Receivership Court's instructions for a status report on NHC. The Receiver requests that the Court approve this Eighth Status Report and the actions taken by the Receiver.

DATED this 6th day of October 2017.

Respectfully submitted:

Barbara D. Richardson, Commissioner of Insurance of the State of Nevada, in her Official Capacity as Statutory Receiver of Delinquent Domestic Insurer

By: /s/ CANTILO & BENNETT, L.L.P.
Special Deputy Receiver
By Its Authorized Representative
Patrick H. Cantilo

Respectfully submitted by:

/s/ Eric W. Swanis
MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
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Counsel for Barbara D. Richardson, Commissioner of Insurance, as the Permanent Receiver for Nevada Health CO-OP

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Las Vegas, Nevada 89169

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of October, 2017, a true and correct copy of the foregoing EIGHTH STATUS REPORT was filed with the Clerk of the Court using the Odyssey eFileNV Electronic Service system and served on all parties with an email-address on record, pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R.

The date and time of the electronic proof of service is in place of the date and place of deposit in the U.S. Mail.

/s/ Joyce Heilich
An employee of Greenberg Traurig, LLP

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EXHIBIT “1”

CANTILO & BENNETT, L.L.P.

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July 6, 2017

BILL SUMMARY

70750 Nevada Health Co-Op ("NHC")

March 1, 2017 - March 31, 2017

Matter No. and Description	Invoice Number	Fees	Costs	Total
March 2017	22000-22013	$147,116.25	$10,277.73	$157,343.98
Totals (1)		$147,116.25	$10,277.73	$157,343.98

Cantilo & Bennett, L.L.P.

NEVADA HEALTH CO-OP
TIMEKEEPER SUMMARY REPORT
3/1/17 - 3/31/17

		Billable Hours	Billable Rate	March 2017 Billing
1	Timekeeper - Patrick H. Cantilo	25.10	$450.00	$11,295.00
2	Timekeeper - Mark F. Bennett	88.00	$375.00	$33,000.00
3	Timekeeper - Kristen W. Johnson	197.70	$175.00	$34,597.50
4	Timekeeper - Josh O. Lively	180.75	$175.00	$31,631.25
5	Timekeeper - Nelson J. Dunlap	0.00	$135.00	$0.00
6	Timekeeper - Arati Bhattacharya	100.30	$200.00	$20,060.00
7	Timekeeper - Law Clerks	0.00	$85.00	$0.00
8	Timekeeper - Isaiah Samaniego	103.50	$100.00	$10,350.00
9	TimeKeeper -- Pierre Riou	24.70	$225.00	$5,557.50
9	TimeKeeper -- Jeffrey L. Collins	5.00	$125.00	$625.00
	GRAND TOTAL	725.05		$147,116.25

Client ID 70750
Work Date 3/1/17:03/31/2017

TimeKeeper		Hours	Fees	NC Hours	NC Fees
MFB MARK F. BENNETT					
70750002	Legal	10.95	4,106.25	0.00	0.00
70750003	Claims	2.65	993.75	0.00	0.00
70750004	Financial Matters	8.25	3,093.75	0.00	0.00
70750006	Provider Issues	0.20	75.00	0.00	0.00
70750008	Company Administration	8.40	3,150.00	0.00	0.00
70750010	CMS	8.80	3,300.00	0.00	0.00
70750015	Tax Issues	0.20	75.00	0.00	0.00
70750100	Asset Recovery	34.50	12,937.50	0.00	0.00
70750102	NHC vs. CMS Litigation	13.75	5,156.25	0.00	0.00
70750201	Partner Re	0.30	112.50	0.00	0.00
Sub Total (MFB)		88.00	33,000.00	0.00	0.00*
ABS ARATI BHATTACHARYA					
70750001	Takeover Administration	100.30	20,060.00	0.00	0.00
Sub Total (ABS)		100.30	20,060.00	0.00	0.00*
PHC PATRICK H. CANTILO					
70750010	CMS	0.50	225.00	0.00	0.00
70750100	Asset Recovery	21.10	9,495.00	0.00	0.00
70750102	NHC vs. CMS Litigation	3.50	1,575.00	0.00	0.00
Sub Total (PHC)		25.10	11,295.00	0.00	0.00*
JLC JEFFREY L. COLLINS					
70750100	Asset Recovery	0.75	93.75	0.00	0.00
70750102	NHC vs. CMS Litigation	4.25	531.25	0.00	0.00
Sub Total (JLC)		5.00	625.00	0.00	0.00*
KWJ KRISTEN W. JOHNSON					
70750001	Takeover Administration	197.70	34,597.50	0.00	0.00
Sub Total (KWJ)		197.70	34,597.50	0.00	0.00*
JOL JOSHUA O. LIVELY		31.00	5,425.00	0.00	0.00
70750002	Legal	76.25	13,343.75	0.00	0.00
70750004	Financial Matters	4.00	700.00	0.00	0.00
70750008	Company Administration	43.50	7,612.50	0.00	0.00
70750100	Asset Recovery	26.00	4,550.00	0.00	0.00
Sub Total (JOL)		180.75	31,631.25	0.00	0.00*
PJR PIERRE J. RIOU					
70750002	Legal	0.30	67.50	0.00	0.00
70750010	CMS	24.40	5,490.00	0.00	0.00
Sub Total (PJR)		24.70	5,557.50	0.00	0.00*
IXS ISAIAH SAMANIEGO					
70750008	Company Administration	103.50	10,350.00	0.00	0.00
Sub Total (IXS)		103.50	10,350.00	0.00	0.00*
Grand Total		725.05	147,116.25	0.00	0.00

Cantilo & Bennett, L.L.P.
Timekeeper Costs by Work Code

Work Date 03/01/2017:03/31/2017
Client ID 70750

Staff ID	Cost Code		Units	Amount	Write Down	Total
	BM1A	BUSINESS MEALS	0.00	1,264.00	0.00	1,264.00
	FD1A	FEDERAL EXPRESS	0.00	30.85	0.00	30.85
	LX1A	LEXIS	0.00	1,480.04	0.00	1,480.04
	PK1A	PARKING	0.00	391.00	0.00	391.00
	PO1E	POSTAGE	0.00	89.41	0.00	89.41
	TA1A	TRAVEL-AIRFARE	0.00	1,943.48	0.00	1,943.48
	TE1A	TRANSPORTATION EXPENSE	0.00	1,297.05	0.00	1,297.05
	TH1A	TRAVEL-HOTEL	0.00	2,016.50	0.00	2,016.50
	TL2E	TELEPHONE	0.00	1,765.40	0.00	1,765.40
	Sub Total ( )		0.00	10,277.73	0.00	10,277.73
Grand Total			0.00	10,277.73	0.00	10,277.73

CANTILO & BENNETT, L.L.P.

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August 14, 2017

BILL SUMMARY

70750 Nevada Health Co-Op ("NHC")

April 1, 2017 - April 30, 2017

Matter No. and Description	Invoice Number	Fees	Costs	Total
April 2017	22051-22052 22081-22090	$124,716.25	$ 7,624.98	$132,659.69
Totals (1)		$124,716.25	$ 7,624.98	$132,659.69

Cantilo & Bennett, L.L.P.

NEVADA HEALTH CO-OP
TIMEKEEPER SUMMARY REPORT
4/1/17 - 4/30/17

		Billable Hours	Billable Rate	February 2017 Billing
1	Timekeeper - Patrick H. Cantilo	28.40	$450.00	$12,780.00
2	Timekeeper - Mark F. Bennett	79.65	$375.00	$29,868.75
3	Timekeeper - Kristen W. Johnson	148.90	$175.00	$26,057.50
4	Timekeeper - Josh O. Lively	150.50	$175.00	$26,337.50
5	Timekeeper - Nelson J. Dunlap	0.00	$135.00	$0.00
6	Timekeeper - Arati Bhattacharya	70.00	$200.00	$14,000.00
7	Timekeeper - Law Clerks	0.00	$85.00	$0.00
8	Timekeeper - Isaiah Samaniego	125.50	$100.00	$12,550.00
9	TimeKeeper -- Pierre Riou	11.10	$225.00	$2,497.50
9	TimeKeeper -- Jeffrey L. Collins	5.00	$125.00	$625.00
	GRAND TOTAL	**619.05**		**$124,716.25**

Cantilo & Bennett, L.L.P.
Timekeeper Submitted Work by Matter

Work Date 04/01/2017:04/30/2017
Client ID 70750

TimeKeeper		Hours	Fees	Rate	NC Hours	NC Fees
MFB MARK F. BENNETT						
70750	Nevada Health CO-OP					
70750002	Legal	11.50	4,312.50	375.00	0.00	0.00
70750003	Claims	3.30	1,237.50	375.00	0.00	0.00
70750004	Financial Matters	5.25	1,968.75	375.00	0.00	0.00
70750008	Company Administration	6.55	2,456.25	375.00	0.00	0.00
70750010	CMS	1.25	468.75	375.00	0.00	0.00
70750100	Asset Recovery	38.00	14,250.00	375.00	0.00	0.00
70750102	NHC vs. CMS Litigation	11.25	4,218.75	375.00	0.00	0.00
70750201	Partner Re	2.55	956.25	375.00	0.00	0.00
Sub Total (MFB)		79.65	29,868.75	375.00	0.00	0.00*
ABS ARATI BHATTACHARYA						
70750	Nevada Health CO-OP					
70750001	Takeover Administration	70.00	14,000.00	200.00	0.00	0.00
Sub Total (ABS)		70.00	14,000.00	200.00	0.00	0.00*
PHC PATRICK H. CANTILO						
70750	Nevada Health CO-OP					
70750002	Legal	4.50	2,025.00	450.00	0.00	0.00
70750003	Claims	0.30	135.00	450.00	0.00	0.00
70750004	Financial Matters	0.30	135.00	450.00	0.00	0.00
70750008	Company Administration	1.00	450.00	450.00	0.00	0.00
70750100	Asset Recovery	20.00	9,000.00	450.00	0.00	0.00
70750102	NHC vs. CMS Litigation	2.00	900.00	450.00	0.00	0.00
70750103	Potential claims against Milliman	0.30	135.00	450.00	0.00	0.00
Sub Total (PHC)		28.40	12,780.00	450.00	0.00	0.00*
JLC JEFFREY L. COLLINS						
70750	Nevada Health CO-OP					
70750100	Asset Recovery	1.75	218.75	125.00	0.00	0.00
70750102	NHC vs. CMS Litigation	3.25	406.25	125.00	0.00	0.00
Sub Total (JLC)		5.00	625.00	125.00	0.00	0.00*
KWJ KRISTEN W. JOHNSON						
70750	Nevada Health CO-OP					
70750001	Takeover Administration	148.90	26,057.50	175.00	0.00	0.00
Sub Total (KWJ)		148.90	26,057.50	175.00	0.00	0.00*
JOL JOSHUA O. LIVELY						
70750	Nevada Health CO-OP					
70750001	Takeover Administration	16.00	2,800.00	175.00	0.00	0.00
70750002	Legal	31.00	5,425.00	175.00	0.00	0.00
70750008	Company Administration	40.75	7,131.25	175.00	0.00	0.00
70750100	Asset Recovery	50.50	8,837.50	175.00	0.00	0.00
70750201	Partner Re	12.25	2,143.75	175.00	0.00	0.00
Sub Total (JOL)		150.50	26,337.50	175.00	0.00	0.00*
PJR PIERRE J. RIOU						
70750	Nevada Health CO-OP					
70750002	Legal	0.40	90.00	225.00	0.00	0.00
70750010	CMS	7.70	1,732.50	225.00	0.00	0.00
70750100	Asset Recovery	3.00	675.00	225.00	0.00	0.00
Sub Total (PJR)		11.10	2,497.50	225.00	0.00	0.00*
IXS ISAIAH SAMANIEGO						
70750	Nevada Health CO-OP					
70750008	Company Administration	125.50	12,550.00	100.00	0.00	0.00
Sub Total (IXS)		125.50	12,550.00	100.00	0.00	0.00*
Grand Total		619.05	124,716.25	201.46	0.00	0.00

Cantilo & Bennett, L.L.P.
Timekeeper Costs by Work Code

Work Date 04/01/2017:04/30/2017
Client ID 70750

Staff ID	Cost Code		Units	Amount	Write Down	Total
	BM1A	BUSINESS MEALS	0.00	1,232.00	0.00	1,232.00
	FD1A	FEDERAL EXPRESS	0.00	545.56	0.00	545.56
	PK1A	PARKING	0.00	247.00	0.00	247.00
	PO1E	POSTAGE	0.00	41.29	0.00	41.29
	SU1A	SUPPLIES	0.00	43.26	0.00	43.26
	TA1A	TRAVEL-AIRFARE	0.00	1,522.46	0.00	1,522.46
	TE1A	TRANSPORTATION EXPENSE	0.00	941.59	0.00	941.59
	TH1A	TRAVEL-HOTEL	0.00	1,888.59	0.00	1,888.59
	TL2E	TELEPHONE	0.00	1,479.80	0.00	1,479.80
	TS1A	TELEPHONE CHARGES	0.00	1.89	0.00	1.89
	Sub Total ( )		0.00	7,943.44	0.00	7,943.44
Grand Total			0.00	7,943.44	0.00	7,943.44

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June 19, 2017

BILL SUMMARY

707500 Nevada Health Co-Op ("NHC")

February 1, 2017 – February 28, 2017

Matter No. and Description	Fees	Costs	Total
February 2017	$16,945.00	$0.00	$16,945.00
Totals (1)	$16,945.00	$0.00	$16,945.00

Palomar Financial, LC

NEVADA HEALTH CO-OP
PRIVILEGED AND CONFIDENTIAL
SUMMARY REPORT
PERIOD FEBRUARY 2017

		Billable Hours	Billable Rate	February 2017 Billing
1	**TIME KEEPER - Nicole Wilkins**	10.65	$250.00	$2,662.50
2	**TIME KEEPER - Johanna Eades**	25.25	$150.00	$3,787.50
3	**TIME KEEPER - Neda Khalaf**	44.50	$160.00	$7,120.00
4	**TIME KEEPER - Susan Roehm**	5.75	$150.00	$862.50
5	**TIME KEEPER - Gayathri Sivadasan**	16.75	$150.00	$2,512.50
6	**TIME KEEPER - Angela Messina**	0.00	$80.00	$0.00
	GRAND TOTAL	**102.90**		**$16,945.00**

Palomar Financial, LC
02/01/2017-02/28/2017
Client: Nevada Health Co-Op ("NHC")

Staff ID	Name	Description	Hours	Amount
NMW	Nicole Wilkins	Payroll & Employee Benefits	1.50	$ 375.00
		Accounts Payable and Receivable	8.10	$ 2,025.00
		Bank Account Admionistration/Reconciliation	1.05	$ 262.50
		Sub Total (NMW)	**10.65**	**$ 2,662.50**
JJE	Johanna Eades	Payroll & Employee Benefits	25.25	$ 3,787.50
		Sub Total (JJE)	**25.25**	**$ 3,787.50**
NK	Neda Khalaf	Accounts Payable and Receivable	44.50	$ 7,120.00
		Sub Total (NK)	**44.50**	**$ 7,120.00**
SER	Susan Roehm	Accounts Payable and Receivable	1.50	$ 225.00
		Claims Matter	2.25	$ 337.50
		InsureMonkey	0.25	$ 37.50
		IT Support & Administration	1.75	$ 262.50
		Sub Total (SER)	**5.75**	**$ 862.50**
GS	Gayathri Sivadasan	Accounts Payable and Receivable	16.75	$ 2,512.50
		Sub Total (GS)	**16.75**	**$ 2,512.50**
	Grand Total		**102.90**	**$ 16,945.00**

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July 7, 2017

BILL SUMMARY

707500 Nevada Health Co-Op ("NHC")

March 1, 2017 – March 31, 2017

Matter No. and Description	Fees	Costs	Total
March 2017	$17,487.50	$0.00	$17,487.50
Totals (1)	$17,487.50	$0.00	$17,487.50

Palomar Financial, LC

NEVADA HEALTH CO-OP
PRIVILEGED AND CONFIDENTIAL
SUMMARY REPORT
PERIOD MARCH 2017

		Billable Hours	Billable Rate	March 2017 Billing
1	**TIME KEEPER - Nicole Wilkins**	18.50	$250.00	$4,625.00
2	**TIME KEEPER - Johanna Eades**	6.50	$150.00	$975.00
3	**TIME KEEPER - Neda Khalaf**	52.50	$160.00	$8,400.00
4	**TIME KEEPER - Susan Roehm**	17.25	$150.00	$2,587.50
5	**TIME KEEPER - Gayathri Sivadasan**	6.00	$150.00	$900.00
6	**TIME KEEPER - Angela Messina**	0.00	$80.00	$0.00
	GRAND TOTAL	**100.75**		**$17,487.50**

Palomar Financial, LC
03/01/2017-03/31/2017
Client: Nevada Health Co-Op ("NHC")

Staff ID	Name	Description	Hours	Amount
NMW	Nicole Wilkins	Accounting Reports/Receivership Team Support	2.15	$ 537.50
		Payroll & Employee Benefits	8.90	$ 2,225.00
		Accounts Payable and Receivable	7.00	$ 1,750.00
		Taxes & Tax Planning	0.45	$ 112.50
		Sub Total (NMW)	**18.50**	**$ 4,625.00**
JJE	Johanna Eades	Payroll & Employee Benefits	6.50	$ 975.00
		Sub Total (JJE)	**6.50**	**$ 975.00**
NK	Neda Khalaf	Accounts Payable and Receivable	52.00	$ 8,320.00
		Taxes & Tax Planning	0.50	$ 80.00
		Sub Total (NK)	**52.50**	**$ 8,400.00**
SER	Susan Roehm	Accounting Reports/Receivership Team Support	0.75	$ 112.50
		Claims Matter	1.00	$ 150.00
		UHH/Javelina	1.75	$ 262.50
		IT Support & Administration	13.75	$ 2,062.50
		Sub Total (SER)	**17.25**	**$ 2,587.50**
GS	Gayathri Sivadasan	Accounts Payable and Receivable	6.00	$ 900.00
		Sub Total (GS)	**6.00**	**$ 900.00**
	Grand Total		**100.75**	**$ 17,487.50**

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August 14, 2017

BILL SUMMARY

707500 Nevada Health Co-Op ("NHC")

April 1, 2017 – April 30, 2017

Matter No. and Description	Fees	Costs	Total
April 2017	$15,542.50	$0.00	$15,542.50
Totals (1)	$15,542.50	$0.00	$15,542.50

Palomar Financial, LC

NEVADA HEALTH CO-OP
PRIVILEGED AND CONFIDENTIAL
SUMMARY REPORT
PERIOD APRIL 2017

		Billable Hours	Billable Rate	April 2017 Billing
1	**TIME KEEPER - Nicole Wilkins**	18.50	$250.00	$4,625.00
2	**TIME KEEPER - Robert Stebel**	8.00	$160.00	$1,280.00
3	**TIME KEEPER - Denise Gonzalez**	4.75	$150.00	$712.50
4	**TIME KEEPER - Neda Khalaf**	26.25	$160.00	$4,200.00
5	**TIME KEEPER - Susan Roehm**	13.75	$150.00	$2,062.50
6	**TIME KEEPER - Gayathri Sivadasan**	17.75	$150.00	$2,662.50
7	**TIME KEEPER - Angela Messina**	0.00	$80.00	$0.00
	GRAND TOTAL	**89.00**		**$15,542.50**

Palomar Financial, LC
04/01/2017-04/30/2017
Client: Nevada Health Co-Op ("NHC")

Staff ID	Name	Description	Hours	Amount
NMW	Nicole Wilkins	Accounting Reports/Receivership Team Support	1.75	$ 437.50
		Payroll & Employee Benefits	10.45	$ 2,612.50
		Accounts Payable and Receivable	5.10	$ 1,275.00
		Bank Account Administration/Reconciliation	0.80	$ 200.00
		Taxes and Tax Planning	0.40	$ 100.00
		Sub Total (NMW)	**18.50**	**$ 4,625.00**
RNS	Robert Stebel	Regulatory Responses/Compliance	8.00	$ 1,280.00
		Sub Total (RNS)	**8.00**	**$ 1,280.00**
DG	Denise Gonzalez	Payroll & Employee Benefits	4.75	$ 712.50
		Sub Total (DG)	**4.75**	**$ 712.50**
NK	Neda Khalaf	Accounts Payable and Receivable	26.25	$ 4,200.00
		Sub Total (NK)	**26.25**	**$ 4,200.00**
SER	Susan Roehm	Accounting Reports/Receivership Team Support	0.75	$ 112.50
		Claims Matter	2.25	$ 337.50
		IT Support & Administration	10.75	$ 1,612.50
		Sub Total (SER)	**13.75**	**$ 2,062.50**
GS	Gayathri Sivadasan	Accounts Payable and Receivable	17.75	$ 2,662.50
		Sub Total (GS)	**17.75**	**$ 2,662.50**
	Grand Total		**89.00**	**$ 15,542.50**

11401 Century Oaks Terrace
Suite 310
Austin, Texas 78758

PALOMAR FINANCIAL, LC

Telephone (512) 404-6555
Facsimile (512) 404-6530
Toll Free (877) 309-7105
www.palomarfin.com

September 6, 2017

BILL SUMMARY

707500 Nevada Health Co-Op ("NHC")

May 1, 2017 – May 31, 2017

Matter No. and Description	Fees	Costs	Total
May 2017	$14,722.50	$0.00	$14,722.50
Totals (1)	$14,722.50	$0.00	$14,722.50

Palomar Financial, LC

NEVADA HEALTH CO-OP
PRIVILEGED AND CONFIDENTIAL
SUMMARY REPORT
PERIOD MAY 2017

		Billable Hours	Billable Rate	May 2017 Billing
1	**TIME KEEPER - Nicole Wilkins**	16.45	$250.00	$4,112.50
2	**TIME KEEPER - Robert Stebel**	0.75	$160.00	$120.00
3	**TIME KEEPER - Burnett Wallace**	4.00	$150.00	$600.00
4	**TIME KEEPER - Neda Khalaf**	29.00	$160.00	$4,640.00
5	**TIME KEEPER - Susan Roehm**	14.50	$150.00	$2,175.00
6	**TIME KEEPER - Gayathri Sivadasan**	20.50	$150.00	$3,075.00
7	**TIME KEEPER - Angela Messina**	0.00	$80.00	$0.00
	GRAND TOTAL	**85.20**		**$14,722.50**

Palomar Financial, LC
05/01/2017-05/31/2017
Client: Nevada Health Co-Op ("NHC")

Staff ID	Name	Description	Hours	Amount
NMW	Nicole Wilkins	Payroll & Employee Benefits	8.35	$ 2,087.50
		Investment Accounting/Support	0.60	$ 150.00
		Accounts Payable and Receivable	7.50	$ 1,875.00
		Sub Total (NMW)	**16.45**	**$ 4,112.50**
RNS	Robert Stebel	Regulatory Responses/Compliance	0.75	$ 120.00
		Sub Total (RNS)	**0.75**	**$ 120.00**
BAW	Burnett Wallace	Payroll & Employee Benefits	4.00	$ 600.00
		Sub Total (BAW)	**4.00**	**$ 600.00**
NK	Neda Khalaf	Accounts Payable and Receivable	29.00	$ 4,640.00
		Sub Total (NK)	**29.00**	**$ 4,640.00**
SER	Susan Roehm	IT Support & Administration	14.50	$ 2,175.00
		Sub Total (SER)	**14.50**	**$ 2,175.00**
GS	Gayathri Sivadasan	Accounts Payable and Receivable	20.50	$ 3,075.00
		Sub Total (GS)	**20.50**	**$ 3,075.00**
	Grand Total		**85.20**	**$ 14,722.50**

GT GreenbergTraurig

Invoice No.: 4538372
File No. : 170678.010100
Bill Date : July 12, 2017

Nevada Health Co-Op
Cantilo & Bennett, L.L.P.
c/o Mark F. Bennett, Esq.
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758

INVOICE

Re: NHC in Receivership

Legal Services through June 30, 2017:

	Total Fees:	$	89,447.50

Expenses:

Filing Fees	3.50		
UPS Charges	10.22		
	Total Expenses:	$	13.72
	Current Invoice:	**$**	**89,461.22**

MEF:TKK
Tax ID: 13-3613083

GT GreenbergTraurig

Invoice No.: 4568920
File No. : 170678.010100
Bill Date : August 24, 2017

Nevada Health Co-Op
Cantilo & Bennett, L.L.P.
c/o Mark F. Bennett, Esq.
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758

INVOICE

Re: NHC in Receivership

Legal Services through July 31, 2017:

	Total Fees:	$	85,138.50

Expenses:

Filing Fees	7.00		
Messenger/Courier Services	15.00		
	Total Expenses:	$	22.00
	Current Invoice:	**$**	**85,160.50**

MEF:TKK
Tax ID: 13-3613083

GT GreenbergTraurig

Invoice No.: 4534075
File No. : 170678.010200
Bill Date : July 10, 2017

Nevada Health Co-Op
Cantilo & Bennett, L.L.P.
c/o Mark F. Bennett, Esq.
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758

Attn: Barbara Richardson
Cantilo & Bennett

INVOICE

Re: Nevada Health Co-Op/adv. Yiming Wu

Legal Services through June 30, 2017:

	Total Fees:	$	1,600.00
Expenses:			
Information and Research	29.70		
	Total Expenses:	$	29.70
	Current Invoice:	**$**	**1,629.70**

EWS:TKK
Tax ID: 13-3613083

GT GreenbergTraurig

Invoice No.: 4561154
File No. : 170678.010200
Bill Date : August 9, 2017

Nevada Health Co-Op
Cantilo & Bennett, L.L.P.
c/o Mark F. Bennett, Esq.
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758

Attn: Barbara Richardson
Cantilo & Bennett

INVOICE

Re: Nevada Health Co-Op/adv. Yiming Wu

Legal Services through July 31, 2017:

	Total Fees:	$	1,400.00

Expenses:

Filing Fees	4.64		
Messenger/Courier Services	10.00		
	Total Expenses:	$	14.64
	Current Invoice:	**$**	**1,414.64**

EWS:TKK
Tax ID: 13-3613083

FTI CONSULTING

Invoice Remittance

Barbara D. Richardson
Nevada Health CO-OP
c/o Mark Bennett
Cantilo & Bennett, LLP
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758
mfbennett@cb-firm.com

June 22, 2017
FTI Invoice No. 7449338
FTI Job No. 425623.0005
Terms NET 30
Federal I.D. No. 52-1261113
Currency: USD

Re: Nevada Health CO-OP in Receivership

Current Invoice Period: Charges Posted through May 31, 2017

Amount Due This Period

Professional Services	$67,252.50
Expenses	$16.89
Amount Due this Period	**$67,269.39**

FTI CONSULTING

Invoice Remittance

Barbara D. Richardson
Nevada Health CO-OP
c/o Mark Bennett
Cantilo & Bennett, LLP
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758
mfbennett@cb-firm.com

July 18, 2017
FTI Invoice No. 7451463
FTI Job No. 425623.0005
Terms NET 30
Federal I.D. No. 52-1261113
Currency: USD

Re: Nevada Health CO-OP in Receivership

Current Invoice Period: Charges Posted through June 30, 2017

Amount Due This Period

Professional Services.....	$80,662.50
Expenses.....	$0.00
Amount Due this Period.....	**$80,662.50**

FTI CONSULTING

Invoice Remittance

Barbara D. Richardson
Nevada Health CO-OP
c/o Mark Bennett
Cantilo & Bennett, LLP
11401 Century Oaks Terrace, Suite 300
Austin, TX 78758
mfbennett@cb-firm.com

August 31, 2017
FTI Invoice No. 7455161
FTI Job No. 425623.0005
Terms NET 30
Federal I.D. No. 52-1261113
Currency: USD

Re: Nevada Health CO-OP in Receivership

Current Invoice Period: Charges Posted through July 31, 2017

Amount Due This Period

Professional Services.....	$39,720.00
Expenses.....	$0.00
Amount Due this Period.....	**$39,720.00**

DeVITO CONSULTING, INC.
JOSEPH J. DeVITO CONSULTING

July 12, 2017

Mr. Mark E. Bennett
Cantilo & Bennett, LLP
11401 Century Oaks Terrace
Suite 300
Austin, TX 78758

Re: Work Related to Nevada Health CO-OP ("NHC")

Dear Mr. Bennett:

The following is a summary of consulting fees incurred from June 1, 2017 through June 30, 2017 in connection with the above-referenced matter.

Total Due - **Consulting Fees** **$62,737.50**

Details of time are provided in the enclosed schedules. Your prompt payment is appreciated.

Very truly yours,

Joseph J. DeVito
President

Enclosures

EXHIBIT “2”

NEVADA HEALTH CO-OP

Cash Flow Analysis

Oct 2015 - Sep 2017

Sources & Uses

Beginning Cash on October 1, 2015	**$**	**5,352,417**
SOURCES:		
Premium Revenue		17,755,920
CSR Recoveries		2,347,121
Rx Rebates		-
Claims Overpayment Recoveries		667,084
PartnerRe 2014 Premium Refund		374,513
Traditional Reins Recoveries		787,352
FTR Reins Recoveries		735,747
Risk Corridor 2014		1,163,872
Federal Receivables Bridge Loan		-
Restricted Cash became Unrestricted		768,517
Other		476,846
TOTAL SOURCES:		***$25,076,972***
USES:		
Medical Claims Q4 2015 and Post 2015 Adj		(161,019)
Rx Claims Q4 2015		(7,599,195)
Risk Adjustment 2015		-
Medical PMPMs Q4		(43,967)
FTR Reinsurance Premium		(898,687)
Traditional Reins Premium Q4 2015		(547,319)
Premium Tax		(294,665)
Other Admin		(9,235,328)
9010 ACA Fee / 720 PCORI Fee		(161,242)
Professional Services		(3,890,795)
TOTAL USES:		***(22,832,217)***
Net cash increase for period		***$2,244,755***
Ending Cash at end of Sep 30, 2017	**$**	**7,597,172**