Advocate Health Care Network and Subsidiaries

FINANCIAL REPORT

For the Third Quarter Ended September 30, 2017

Advocate Health Care

Cautionary Statement Regarding Forward Looking Statements in this Quarterly Financial Report

This Quarterly Report contains "forward-looking statements" within the meaning of the federal securities laws. Forward-looking statements are those statements that do not relate solely to historical or current fact, and can often be identified by use of words including but not limited to "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan," or "continue." These forward-looking statements are based on the current plans and expectations of Advocate Health Care Network and Subsidiaries ("Advocate") that, although believed to be reasonable, are subject to a number of known and unknown uncertainties and risks inherent in the operation of health care facilities, many of which are beyond Advocate's control, that could significantly affect current plans and expectations and Advocate's future financial position and results of operations. These uncertainties and risks include, but are not limited to, the following:

- potential federal or state reform of health care, implementation of the Patient Protection and Affordable Care Act ("ACA") and related rules and regulations, and any potential modifications, challenges or repeal of the ACA or any other such legislation;
- the highly competitive nature of the health care business;
- pressures to contain costs by managed care organizations, insurers, health care providers and Advocate's ability to negotiate acceptable terms with third party payors;
- changes in the Medicare and Medicaid programs that may impact reimbursements to health care providers and insurers, as well as possible additional changes in such programs;
- Advocate's ability to attract and retain qualified management and other personnel, including physicians, nurses and medical support personnel;
- liabilities and other claims asserted against Advocate;
- changes in accounting standards and practices;
- changes in general economic conditions;
- future divestitures or acquisitions;
- changes in revenue mix or delays in receiving payments from third party payors, as has been the case in Illinois;
- the availability and cost of capital to fund future expansion plans of Advocate and to provide for ongoing capital expenditure needs;
- changes in business strategy or development plans;
- Advocate's ability to implement shared services and other initiatives and realize decreases in administrative, supply and infrastructure costs;
- the outcome of pending and any future litigation;
- the ability to achieve expected levels of patient volumes and control the costs of providing services;
- tax reform proposals of the U.S. House of Representatives and Senate passed in November 2017
- results of reviews of Advocate's cost reports; and
- increased costs from further government regulation of health care and Advocate's failure to comply, or allegations of any failure to comply, with applicable laws and regulations, including without limitation, laws, regulations, policies and procedures relating to the status of Advocate and certain of its subsidiaries as tax-exempt organizations as well as its ability to comply with the requirements of Medicare and Medicaid programs.

These forward-looking statements speak only as of the date made. Except as required by law, Advocate has undertaken no obligation to publicly update or revise any forward-looking statement contained in this Quarterly Report, whether as a result of new information, future events or otherwise. Therefore, current plans, anticipated actions and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of Advocate. Investors are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this Quarterly Report.

Advocate Health Care Network and Subsidiaries
For the Third Quarter Ended September 30, 2017

C O N T E N T S

Advocate Health Care Network and Subsidiaries
Interim Condensed Consolidated Balance Sheets

(dollars in thousands)

	Unaudited September 30, 2017	Note 1 December 31, 2016
Assets		
Current assets:		
Cash and cash equivalents	$ 342,897	$ 151,588
Short term investments	15,403	22,837
Assets limited as to use:		
Internally designated for self insurance programs	87,729	83,524
Patient accounts receivable		
less allowances for uncollectible accounts of $230,481 and $242,973	803,083	680,979
Amounts due from primary third-party payors	31,248	25,898
Prepaid expenses, inventories and other current assets	453,410	319,803
Collateral proceeds received under securities lending program	17,324	19,953
Total current assets	1,751,094	1,304,582
Assets limited as to use:		
Externally designated under debt agreements, net of amounts required to meet current obligations	7,239	6,053
Internally designated for capital improvement	5,000,027	4,845,378
Internally designated for self insurance programs, less current portion	711,236	634,464
Externally designated for capital improvement, medical education and health care programs	62,153	57,928
Investments under securities lending program	17,085	19,564
	5,797,740	5,563,387
Interests in health care and related entities	147,337	144,282
Reinsurance receivable	89,716	97,603
Other noncurrent assets	228,743	210,027
	6,263,536	6,015,299
Property and equipment -- at cost:		
Property and equipment	5,908,318	5,711,569
Less allowances for depreciation	2,920,993	2,766,283
	2,987,325	2,945,286
	$ 11,001,955	$ 10,265,167

***Note 1**: December 31, 2016 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2016 Audited Consolidated Financial Statements, available on the Electronic Municipal Market Access website (*www.emma.msrb.org*).*

See accompanying notes to interim condensed consolidated financial statements.

The Interim Condensed Consolidated Financial Statements were prepared on October 16, 2017.

Advocate Health Care Network and Subsidiaries
Interim Condensed Consolidated Balance Sheets
(continued)
(dollars in thousands)

	Unaudited September 30, 2017	Note 1 December 31, 2016
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ 27,016	$ 25,892
Long-term debt subject to short-term remarketing arrangements	91,975	91,975
Accounts payable and accrued expenses	430,452	508,413
Accrued salaries and employee benefits	449,123	431,333
Amounts due to primary third-party payors	506,077	320,711
Current portion of accrued insurance and claims costs	102,061	100,225
Obligations to return collateral under securities lending program	17,324	19,953
Total current liabilities	1,624,028	1,498,502
Noncurrent liabilities:		
Long-term debt, less current portion	1,539,705	1,552,919
Pension plan liability	19,143	20,202
Accrued insurance and claims costs, less current portion	685,968	666,496
Accrued losses subject to insurance recovery	89,716	97,603
Obligations under swap agreements, net of collateral posted	81,362	79,622
Other noncurrent liabilities	241,411	221,574
Total noncurrent liabilities	2,657,305	2,638,416
Total liabilities	4,281,333	4,136,918
Net assets:		
Unrestricted	6,551,915	5,964,762
Temporarily restricted	114,623	109,014
Permanently restricted	53,222	52,975
	6,719,760	6,126,751
Non-controlling interest	862	1,498
Total net assets	6,720,622	6,128,249
	$ 11,001,955	$ 10,265,167

***Note 1**: December 31, 2016 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2016 Audited Consolidated Financial Statements, available on the Electronic Municipal Market Access website (www.emma.msrb.org).*

See accompanying notes to interim condensed consolidated financial statements.

The Interim Condensed Consolidated Financial Statements were prepared on October 16, 2017.

Advocate Health Care Network and Subsidiaries
Interim Condensed Consolidated Statements of Operations and Changes in Net Assets

(dollars in thousands)

	Unaudited For the Quarter Ended September 30,		Unaudited For the Nine Months Ended September 30,		Note 1 For the Year Ended December 31,
	2017	**2016**	**2017**	**2016**	**2016**
Unrestricted revenues and other support					
Net patient service revenue	**$ 1,166,924**	$ 1,272,035	**$ 3,532,750**	$ 3,749,176	**$ 5,062,334**
Provision for uncollectible accounts	**(52,229)**	(89,678)	**(173,706)**	(187,793)	**(269,463)**
	1,114,695	1,182,357	**3,359,044**	3,561,383	**4,792,871**
Capitation revenue	**331,988**	111,093	**976,938**	366,000	**487,796**
Other revenue	**107,335**	71,904	**281,253**	231,774	**306,753**
	1,554,018	1,365,354	**4,617,235**	4,159,157	**5,587,420**
Expenses					
Salaries, wages and employee benefits	**784,579**	733,947	**2,331,770**	2,194,147	**2,963,613**
Purchased services and operating supplies	**348,285**	349,628	**1,039,588**	1,024,899	**1,395,329**
Contracted medical services	**156,309**	41,632	**435,893**	151,584	**209,265**
Other	**79,535**	66,480	**271,688**	258,214	**282,433**
Medicaid assessment	**40,721**	39,292	**121,736**	110,396	**149,609**
Depreciation and amortization	**73,484**	71,047	**219,289**	207,338	**268,846**
Interest	**14,873**	14,263	**44,370**	40,426	**54,721**
	1,497,786	1,316,289	**4,464,334**	3,987,004	**5,323,816**
Operating income	**56,232**	49,065	**152,901**	172,153	**263,604**
Nonoperating income (loss)					
Investment income	**123,963**	184,183	**443,653**	292,617	**329,119**
Change in the fair value of interest rate swaps	**(544)**	530	**(1,740)**	(25,894)	**9,221**
Other nonoperating items, net	**(4,124)**	(2,023)	**(6,270)**	(6,050)	**(4,340)**
Loss on refinancing of debt	**(5,971)**	-	**(5,971)**	-	**-**
	113,324	182,690	**429,672**	260,673	**334,000**
Revenues in excess of expenses	**$ 169,556**	$ 231,755	**$ 582,573**	$ 432,826	**$ 597,604**

***Note 1**: December 31, 2016 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2016 Audited Consolidated Financial Statements, available on the Electronic Municipal Market Access website (www.emma.msrb.org).*

See accompanying notes to interim condensed consolidated financial statements.

The Interim Condensed Consolidated Financial Statements were prepared on October 16, 2017.

Advocate Health Care Network and Subsidiaries
Interim Condensed Consolidated Statements of Operations and Changes in Net Assets
(continued)
(dollars in thousands)

	Unaudited For the Quarter Ended September 30,		Unaudited For the Nine Months Ended September 30,		Note 1 For the Year Ended December 31,
	2017	**2016**	**2017**	**2016**	**2016**
Unrestricted net assets					
Revenues in excess of expenses	**$ 169,556**	$ 231,755	**$ 582,573**	$ 432,826	**$ 597,604**
Contributions received from a supporting foundation and grants used for capital purposes	**1,043**	3,892	**4,582**	6,498	**9,430**
Post retirement benefit plan adustments	**-**	-	**-**	-	**6,044**
Other	**(89)**	(1)	**(2)**	(2)	**-**
Increase in unrestricted net assets	**170,510**	235,646	**587,153**	439,322	**613,078**
Temporarily restricted net assets					
Contributions for medical education programs, capital purchases, and other purposes	**4,282**	4,159	**9,947**	10,281	**14,633**
Realized gains on investments	**1,237**	510	**2,418**	1,260	**1,031**
Unrealized gains on investments	**1,209**	2,505	**5,578**	3,759	**3,837**
Net assets released from restrictions and used for operations, for capital purposes, for medical education programs and other purposes	**(4,006)**	(6,861)	**(12,334)**	(15,054)	**(22,070)**
Increase (decrease) in temporarily restricted net assets	**2,722**	313	**5,609**	246	**(2,569)**
Permanently restricted net assets					
Contributions for medical education programs, capital purchases, and other purposes	**51**	281	**247**	700	**4,358**
Increase in permanently restricted net assets	**51**	281	**247**	700	**4,358**
Increase in net assets	**173,283**	236,240	**593,009**	440,268	**614,867**
Change in non-controlling interest	**187**	314	**(636)**	(222)	**136**
Net assets at beginning of period	**6,547,152**	5,716,738	**6,128,249**	5,513,246	**5,513,246**
Net assets at end of period	**$ 6,720,622**	**$ 5,953,292**	**$ 6,720,622**	**$ 5,953,292**	**$ 6,128,249**

***Note 1**: December 31, 2016 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2016 Audited Consolidated Financial Statements, available on the Electronic Municipal Market Access website (www.emma.msrb.org).*

See accompanying notes to interim condensed consolidated financial statements.

Advocate Health Care Network and Subsidiaries
Interim Condensed Consolidated Statements of Cash Flows
(dollars in thousands)

	Unaudited For the Quarter Ended September 30,		Unaudited For the Nine Months Ended September 30,		Note 1 For the Year Ended December 31,
	2017	2016	2017	2016	2016
Operating activities					
Increase in net assets	**$ 173,470**	$ 236,554	**$ 592,373**	$ 440,046	**$ 615,003**
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:					
Depreciation, amortization and accretion	**72,139**	69,685	**215,252**	203,241	**263,387**
Provision for uncollectible accounts	**52,229**	89,678	**173,706**	187,793	**269,463**
Deferred income taxes	**-**	-	**342**	-	**(13,685)**
Losses (gains) on disposal of property and equipment	**2,296**	(1,143)	**1,697**	(1,925)	**942**
Loss on refinancing of debt	**5,971**	-	**5,971**	-	**-**
Change in fair value of interest rate swaps	**544**	(530)	**1,740**	25,894	**(9,221)**
Postretirement benefit plan adjustments	**-**	-	**-**	-	**(6,044)**
Restricted contributions and gains on investments, net of assets released from restrictions used for operations	**(2,963)**	(2,969)	**(7,752)**	(8,556)	**(12,640)**
Change in operating assets and liabilities:					
Trading securities	**(83,806)**	(203,141)	**(316,323)**	(289,996)	**(437,653)**
Patient accounts receivable	**(137,790)**	(76,625)	**(295,778)**	(205,914)	**(346,819)**
Amounts due to/from primary third-party payors	**110,134**	(33,588)	**180,017**	(11,576)	**(8,703)**
Accounts payable, accrued salaries, employee benefits, accrued expenses and other noncurrent liabilities	**167,196**	16,688	**(128,122)**	13,303	**137,152**
Other assets	**(91,903)**	(5,520)	**(120,709)**	(13,327)	**(57,950)**
Accrued insurance and claims costs	**(7,710)**	(5,212)	**21,308**	43,695	**(49,859)**
Net cash provided by operating activities	**259,807**	83,877	**323,722**	382,678	**343,373**
Investing activities					
Purchases of property and equipment	**(93,559)**	(92,277)	**(269,705)**	(303,798)	**(401,868)**
Proceeds from sale of property and equipment	**60**	6,124	**5,194**	7,221	**8,273**
Cash and investments acquired in the acquistion of Advocate Physician Partners	**-**	-	**157,285**	-	**-**
Net sales and purchases of investments designated as nontrading	**(1,443)**	(4,771)	**(1,186)**	27,310	**31,926**
Other	**(6,641)**	(5,479)	**(25,804)**	(17,494)	**(33,387)**
Net cash used in investing activities	**(101,583)**	(96,403)	**(134,216)**	(286,761)	**(395,056)**
Financing activities					
Payment of long-term debt	**(115,566)**	(480)	**(131,387)**	(15,258)	**(25,210)**
Proceeds from issuance of long-term debt	**115,000**	-	**115,000**	-	**-**
Collateral (posted) returned under interest rate swap agreements	**-**	(2,284)	**-**	(20,350)	**830**
Proceeds from restricted contributions and gains on investments	**6,779**	7,455	**18,190**	16,000	**23,859**
Net cash provided by (used in) financing activities	**6,213**	4,691	**1,803**	(19,608)	**(521)**
Increase (decrease) in cash and cash equivalents	**164,437**	(7,835)	**191,309**	76,309	**(52,204)**
Cash and cash equivalents at beginning of period	**178,460**	287,936	**151,588**	203,792	**203,792**
Cash and cash equivalents at end of period	**$ 342,897**	$ 280,101	**$ 342,897**	$ 280,101	**$ 151,588**

***Note 1**: December 31, 2016 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2016 Audited Consolidated Financial Statements, available on the Electronic Municipal Market Access website (www.emma.msrb.org).*

See accompanying notes to interim condensed consolidated financial statements.

The Interim Condensed Consolidated Financial Statements were prepared on October 16, 2017.

Advocate Health Care Network and Subsidiaries
Notes to Interim Condensed Consolidated Financial Statements

As of and for the Third Quarter Ended September 30, 2017

(dollars shown in tables are in thousands except as noted)

Note A – Basis of Presentation

The accompanying Interim Condensed Consolidated Financial Statements for the third quarters ended September 30, 2017 and 2016 have been prepared in accordance with accounting principles generally accepted in the United States applied on a basis substantially consistent with that of the 2016 audited consolidated financial statements of Advocate Health Care Network and Subsidiaries ("Advocate"). In the opinion of management, all adjustments (consisting of normal recurring accruals) considered necessary for a fair presentation have been included. The interim condensed consolidated financial statements do not include all the information and footnotes required by accounting principles generally accepted in the United States for complete financial statements. Operating results for the quarter and nine months ended September 30, 2017 are not necessarily indicative of the results that may be experienced during the year ending December 31, 2017.

To better align Advocate's and Advocate Health Partner's (d/b/a Advocate Physician Partners) ("APP") resources related to capitated and other risk arrangements, the APP bylaws were amended effective January 1, 2017. The amendment resulted in Advocate obtaining a majority of board seats and certain reserve powers. Accordingly, APP's financial statements were consolidated in Advocate's financial statements beginning January 1, 2017.

Note B – Accounting Pronouncements

New Accounting Pronouncements

In March 2017, the Financial Accounting Standards Board ("FASB") issued guidance related to the presentation of net periodic pension cost. This new guidance requires that the service cost component be reported in the same line item as compensation costs arising from services rendered by the pertinent employees during the period. The other components of net pension benefit costs are required to be presented separately from the service cost component and outside a subtotal of income from operations. This new guidance is effective for fiscal years, and interim periods within those fiscal years, beginning after December 31, 2017. Management has evaluated the effect of this guidance on the Interim Condensed Consolidated Statements and has determined that this guidance will reduce operating income but will have no effect on revenues in excess of expenses on the Consolidated Statements of Operations and Changes in Net Assets. This guidance will not have an effect on the measurement of pension cost nor presentation of pension plan liabilities in the Consolidated Balance Sheets.

In November 2016, the FASB issued guidance related to the statement of cash flows. The guidance will require restricted cash and restricted cash equivalents to be included with cash and cash equivalents when reconciling the beginning of period and end of period total amounts shown on the statement of cash flows. This guidance is effective for the fiscal years, and interim periods within those fiscal years, beginning after December 15, 2017.

In August 2016, the FASB issued guidance related to the presentation of financial statements of not-for-profit entities. The guidance will require net assets to be categorized either as net assets with donor restrictions or net assets without donor restrictions rather than the currently required three classes of net assets. The guidance also requires additional quantitative and qualitative disclosures and disclosure of expenses by their natural and functional classifications. This guidance is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2017. Advocate is evaluating the effect this guidance will have on its consolidated financial statements; however, the guidance is not expected to have an effect on revenues in excess of expenses on the Consolidated Statements of Operations and Changes in Net Assets.

In February 2016, the FASB issued guidance related to lease accounting. The guidance will require leases that are classified as operating leases under current guidance to be recognized on the balance sheet as lease assets and liabilities by lessees. This new guidance is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Advocate is evaluating the effect this guidance will have on its consolidated financial statements.

In January 2016, the FASB issued guidance requiring financial instruments accounted for on the equity method to be measured at fair value with changes in fair value recognized in net income. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2017. Advocate is evaluating the effect this guidance will have on its consolidated financial statements.

In May 2014, the FASB issued guidance related to recognizing revenue from contracts with customers. This new guidance dictates that the standard be applied either retrospectively to each prior reporting period presented, or retrospectively with the cumulative effect of initially applying the revenue recognition standard recognized at the date of initial application. This new guidance is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2017. Advocate is evaluating the effect this guidance will have on its consolidated financial statements.

Note C- Reclassifications in the Condensed Consolidated Financial Statements

Certain reclassifications were made to the 2016 interim condensed consolidated financial statements and footnotes to conform to the classifications used in 2017. There was no impact on previously reported 2016 net assets or revenues in excess of expenses.

Note D – Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates, assumptions and judgments that affect the reported amounts of assets and liabilities and amounts disclosed in the notes to the financial statements at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Although estimates are considered to be fairly stated at the time made, actual results could differ materially from those estimates.

Advocate considers critical accounting policies to be those that require the more significant judgments and estimates in the preparation of its financial statements, including, but not limited to, the following:

recognition of patient service revenue, which includes, contractual allowances, third-party payor settlements, contracted medical service expense recognition and reserves for incurred but not reported claims; accounting for asset impairment or disposal of long-lived assets; provisions for uncollectible accounts and charity care allowances; reserves for losses and expenses related to health care professional, general and other self-insured liability risks; analysis of potential other than temporary declines in fair value of non-trading investments; accounting for swap valuations; and pension plan actuarial assumptions. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Although estimates are considered to be reasonable at the time made, actual results could differ materially from those estimates.

Changes in estimates that relate to prior years' third-party payment arrangements resulted in a decrease to net patient service revenue of $0.5 million and an increase of $0.1 million for the quarters ended September 30, 2017 and 2016, respectively; $0.9 million decrease and $4.9 million increase for the nine months ended September 30, 2017 and 2016, respectively; and increase of $12.9 million for the year ended December 31, 2016.

Note E – Net Patient Service Revenue, Patient Accounts Receivable and Capitation Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Patient accounts receivable are stated at net realizable value. Advocate evaluates the collectability of its accounts receivable based on the length of time the receivable is outstanding, major payor sources of revenue, historical collection experience and trends in health care insurance programs to estimate the appropriate allowance and provision for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, Advocate analyzes contractually due amounts and provides an allowance for contractual allowances and an allowance and an allowance for uncollectible accounts for patient responsibilities under such contracts that are deemed not realizable. For receivables associated with self-pay patients, Advocate records an allowance for uncollectible accounts in the period of service based on its past experience. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods.

The allowance for uncollectible accounts as a percentage of accounts receivable was 22% and 26% at September 30, 2017 and December 31, 2016, respectively.

Advocate has commercial and Medicare HMO agreements and PPO arrangements to provide medical services to subscribing participants. Under these agreements, Advocate receives monthly payments, reflected as capitation revenue in the statement of operations and changes in net assets, primarily based on the number of participants, regardless of actual medical services provided to participants.

Note F – Investments

Substantially all investments and assets limited as to use are classified as trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices. Investments in limited partnerships that invest in marketable securities and derivative products ("hedge funds") are reported using the equity method of accounting based on information provided by the respective partnership. Investments in private equity limited partnerships with ownership percentages over 5% are recorded on the equity method of accounting, while those with ownership percentages of 5% or less are recorded using the cost method of accounting. For private equity investments carried at cost, Advocate regularly compares the net asset value ("NAV"), which is a proxy for the fair value, to the recorded cost of these investments for potential other-than-temporary impairment. The cost of these investments is $596.6 million and $523.3 million and the NAV of these, based on estimates determined by the investments' manager, was $713.8 million and $603.8 million at September 30, 2017 and December 31, 2016, respectively. For the nine months ended September 30, 2017 and 2016, Advocate identified and recorded $2.6 million and $1.0 million, respectively, and $1.3 million for the year ended December 31, 2016 of impairment losses that are included in investment income in the interim condensed consolidated statements of operations and changes in net assets.

Receivables and payables for investment trades not settled are presented with prepaid expenses, inventories and other current assets and accounts payable and accrued expenses. Unsettled sales resulted in receivables due from brokers of $25.7 million and $16.7 million at September 30, 2017 and December 31, 2016, respectively. Unsettled purchases resulted in payables of $72.4 million and $94.1 million at September 30, 2017 and December 31, 2016, respectively.

Investment income or loss (including realized gains and losses, interest, dividends, changes in equity of limited partnerships and unrealized gains and losses) is included in investment income unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue. Gains and losses which are restricted by donor or law are reported as a change in temporarily restricted net assets.

Investment returns for assets limited as to use, cash and cash equivalents and short-term investments are comprised of the following:

	For the Quarter Ended September 30,		For the Nine Months Ended September 30,		For the Year Ended December 31,
	2017	2016	**2017**	2016	**2016**
Interest and dividend income	**$ 13,180**	$ 15,368	**$ 40,727**	$ 43,842	**$ 56,703**
Equity income from alternative investments	**24,134**	66,306	**98,737**	121,538	**189,615**
Net realized gains (losses)	**30,841**	7,442	**48,495**	(775)	**(20,969)**
Net unrealized gains	**67,817**	108,417	**298,873**	161,420	**148,457**
	$ 135,972	$ 197,533	**$ 486,832**	$ 326,025	**$ 373,806**

Investment returns are included in the consolidated statements of operation and changes in net assets as follows:

	For the Quarter Ended September 30,		For the Nine Months Ended September 30,		For the Year Ended December 31,
	2017	2016	**2017**	2016	**2016**
Other revenue	**$ 9,563**	$ 10,335	**$ 35,183**	$ 28,389	**$ 39,819**
Investment income	**123,963**	184,183	**443,653**	292,617	**329,119**
Temporarily resticted net assets realized and change in unrealized gains	**2,446**	3,015	**7,996**	5,019	**4,868**
	$ 135,972	$ 197,533	**$ 486,832**	$ 326,025	**$ 373,806**

Investments in hedge funds totaled $1,937.7 million and $1,961.3 million at September 30, 2017 and December 31, 2016, respectively. Investments in private equity limited partnerships totaled $762.4 million and $651.6 million at September 30, 2017 and December 31, 2016, respectively. At September 30, 2017, Advocate had commitments to fund, including recallable distributions, an additional $831.1 million to private equity limited partnerships over approximately the next seven years.

Note G – Fair Value Measurements

Advocate accounts for certain assets and liabilities at fair value. The hierarchy below lists three levels of fair value based on the extent to which inputs used in measuring fair value is observable in the market.

Advocate categorizes each fair value measurement in one of three levels based on the lowest level input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices in active markets for identified assets or liabilities.

Level 2: Inputs, other than the quoted process in active markets that are observable either directly or indirectly.

Level 3: Unobservable inputs in which there is little or no market data, which then requires the reporting entity to develop its own assumptions about what market participants would use in pricing the asset or liability.

The following section describes the valuation methodologies Advocate uses to measure financial assets and liabilities at fair value. In general, where applicable, Advocate uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments such as domestic and international equities, United States Treasuries, exchange-traded funds, and agency securities. If quoted prices in active markets for identical assets and liabilities are not available to determine fair

value, then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, commercial paper and certain agency securities. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include adjustments related to Advocate's credit risk.

Advocate's investments are exposed to various kinds and levels of risk. Equity securities and equity funds expose Advocate to market risk, performance risk and liquidity risk for both domestic and international investments. Market risk is the risk associated with major movements of the equity markets. Performance risk is that risk associated with a company's operating performance. Fixed income securities and fixed income mutual funds expose Advocate to interest rate risk, credit risk and liquidity risk. As interest rates change, the value of many fixed income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value resulting in additional gains and losses in the near term.

The carrying values of cash and cash equivalents, accounts receivable and payable, accrued expenses and short-term borrowings are reasonable estimates of their fair values due to the short-term nature of these financial instruments.

Description	September 30, 2017	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 500,344	$ 483,654	$ 16,690	$ -
Corporate Bonds and other debt securities	356,359	-	356,359	-
United States goverment obligations	415,400	-	415,400	-
Bond and other debt security mutual funds	448,354	105,517	342,837	-
Equity securities	961,470	961,470	-	-
Equity funds	861,733	96,446	765,287	-
Investment at fair value	**$ 3,543,660**	**$ 1,647,087**	**$ 1,896,573**	**$ -**
Investment not at fair value	2,700,109			
Total investments	**$ 6,243,769**			
Collateral proceeds received under securities lending program	**$ 17,324**		**$ 17,324**	
Liabilities				
Derivatives:				
Obligations under interest rate swap agreements, net	**$ (81,362)**		**$ (81,362)**	
Obligations to return capital under securities lending program	**$ (17,324)**		**$ (17,324)**	

Description	December 31, 2016	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 322,650	$ 306,598	$ 16,052	$ -
Corporate Bonds and other debt securities	489,400	-	489,400	-
United States goverment obligations	489,937	-	489,937	-
Bond and other debt security mutual funds	272,136	115,207	156,929	-
Equity securities	933,478	933,478	-	-
Equity funds	700,828	73,138	627,690	-
Investment at fair value	**$ 3,208,429**	**$ 1,428,421**	**$ 1,780,008**	**$ -**
Investment not at fair value	2,612,907			
Total investments	**$ 5,821,336**			
Collateral proceeds received under securities lending program	**$ 19,953**		**$ 19,953**	
Liabilities				
Derivatives:				
Obligations under interest rate swap agreements, net	**$ (79,622)**		**$ (79,622)**	
Obligations to return capital under securities lending program	**$ (19,953)**		**$ (19,953)**	

The Interim Condensed Consolidated Financial Statements were prepared on October 16, 2017.

Investments not at fair value include hedge funds and private equity limited partnerships ("alternative investments"). The values of the alternative investments that do not have readily determinable fair values are determined by the general partner or fund manager taking into consideration, among other things, the cost of the securities or other investments, prices of recent significant transfers of like assets and subsequent developments concerning the companies or other assets to which the alternative investments relate.

Note H – Long-Term Debt

Advocate's outstanding bonds are secured by obligations issued under the Amended and Restated Master Trust Indenture dated as of September 1, 2011, with Advocate Health Care Network, Advocate Health and Hospitals Corporation ("AHHC"), Advocate Condell Medical Center ("ACMC"), Advocate Sherman Hospital ("ASH") and Advocate North Side Health Network ("ANS") (the "Obligated Group") and U.S. Bank National Association, as master trustee (the "Advocate Master Indenture"). Under the terms of the bond indentures and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The Advocate Master Indenture and other debt agreements, including bank credit agreements, also place restrictions on Advocate and require Advocate to maintain certain financial ratios.

Advocate's unsecured variable rate revenue bonds at September 30, 2017, Series 2008C-3B of $22.0 million and Series 2011B of $70.0 million, while subject to a long-term amortization period, may be put to Advocate at the option of the bondholders on certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within a maximum of twelve months after September 30, 2017, the principal amount of such bonds has been classified as a current obligation in the accompanying condensed consolidated balance sheets. Management believes the likelihood of a material amount of bonds being put to Advocate is remote. However, to address this possibility, Advocate has taken steps to provide various sources of liquidity, including accessing alternate sources of financing, including lines of credit and/or unrestricted assets as a source of self-liquidity. On April 19, 2016, notice was received that $11.5 million of the Series 2011B bonds were tendered – see the Liquidity and Capital Resource section in the accompanying Management Discussion and Analysis of Financial Condition and Results of Operations for a description of the remarketing process for the Series 2011B bonds. On May 5, 2016, the Series 2003C bonds in the amount of $16.7 million were remarketed to their final maturity date of November 15, 2022. On July 21, 2016, the Series 2003A Bonds in the amount of $17.4 million were remarketed to their final maturity date of November 15, 2022. On July 20, 2017, the Series 2008C-3B Bonds in the amount of $22.0 million were remarketed for a new one year interest period and are next subject to mandatory tender on July 30, 2018.

On September 29, 2017, Advocate entered into a taxable term loan agreement, which matures on September 29, 2024, in the amount of $115.0 million. The proceeds of the loan were used to advance refund $106.0 million of the Series 2010 A, B, C and D Bonds.

Advocate has standby bond purchase agreements (each an "SBPA") with banks to provide liquidity support for substantially all the Series 2008C Bonds. In the event of a failed remarketing of the supported Series 2008C Bonds upon its tender by an existing holder and subject to compliance with the terms of the SBPA, the standby bank would provide the funds for the purchase of such tendered bonds, and Advocate would be obligated to repay the bank for the funds it provided for such bond purchase (if such bond is not subsequently remarketed), with the first installment of such repayment commencing on the date one year and one day after the bank purchases the bond. As of September 30, 2017 and December 31, 2016, there were no bank purchased

bonds outstanding. The following table provides the outstanding par value at September 30, 2017 and associated SBPA's expiration date.

Series	Par Outstanding (dollars in millions)	SBPA Expiration
2008C-1	$ 129.5	August 01, 2020
2008C-2A	49.8	August 01, 2019
2008C-2B	58.2	August 15, 2021
2008C-3A	87.7	August 15, 2021

Advocate has in place certain interest rate swaps associated with its variable rate Series 2008C Bonds; these swaps effectively convert these Series 2008C Bonds to a fixed rate of 3.605%. Additional information about the Advocate interest rate swap program relating to certain of Advocate's variable rate debt is described in Note I – Derivatives, and in the Guarantees of Debt, Swaps and Other Derivatives and Financing Arrangements section of the Management Discussion and Analysis of Financial Condition and Results of Operations.

Interest paid, net of capitalized interest, amounted to $40.4 million and $37.6 million for the nine months ended September 30, 2017 and 2016, respectively, and $57.5 million for the year ended December 31, 2016. Advocate capitalized interest of $2.2 million and $5.9 million for the nine months ended September 30, 2017 and 2016, respectively, and $7.3 million for the year ended December 31, 2016.

Maturities of long-term debt, capital leases and sinking fund requirements, assuming remarketing of any variable rate bonds subject to tender, for the five years ending September 30, 2022, are as follows: 2018 – $27.0 million; 2019 – $36.0 million; 2020 – $33.7 million; 2021 – $34.5 million; and 2022 – $36.5 million.

At September 30, 2017, Advocate had lines of credit with banks aggregating to $325.0 million. These lines of credit provide for various interest rates and payment terms and expire as follows: $100.0 million in March 2018, $100.0 million in August 2018 and $100.0 million in December 2019, and $25.0 million in August 2020. These lines of credit may be used to redeem bonded indebtedness, to pay costs related to such redemptions, for capital expenditures, or for general working capital purposes. At September 30, 2017, no amounts were outstanding on these lines of credit.

Note I – Derivatives

Advocate has interest rate-related derivative instruments to manage exposure of its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management. By using derivative financial instruments to manage the risk of changes in interest rates, Advocate exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes Advocate, which creates credit risk for Advocate. When the fair value of a derivative contract is negative, Advocate owes the counterparty, and therefore, it does not possess credit risk. Advocate minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of Advocate based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that

limit the types and degree of market risk that may be undertaken. Advocate also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

At September 30, 2017 Advocate maintains an interest rate swap program on its Series 2008C variable rate demand revenue bonds. These bonds expose Advocate to variability in interest payments due to changes in interest rates. Advocate believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, Advocate entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps convert the variable rate cash flow exposure on the variable rate demand revenue bonds to synthetically fixed cash flows. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in the principal outstanding under various bond series. The following is a summary of the outstanding positions under these interest rate swap agreements at September 30, 2017 and December 31, 2016:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	$129,900	Nov. 1, 2038	61.7% of LIBOR + 26 bps	3.605%
2008C-2	$108,425	Nov. 1, 2038	61.7% of LIBOR + 26 bps	3.605%
2008C-3	$ 88,000	Nov. 1, 2038	61.7% of LIBOR + 26 bps	3.605%

The swaps are not designated as hedging instruments, and therefore, hedge accounting has not been applied. As such, unrealized changes in fair value of the swaps are included as a component of nonoperating income (loss) in the interim condensed consolidated statements of operations and changes in net assets as changes in the fair value of interest rate swaps. The net cash settlement payments, representing the realized changes in fair value of the swaps, are included as interest expense in the interim condensed consolidated statements of operations and changes in net assets.

The fair value of the interest rate swap agreements was as follows:

	September 30, 2017	December 31, 2016
Obligations under swap agreements	**$ (81,362)**	$ (79,622)
Collateral posted under swap agreements	**-**	-
Obligations under swap agreements, net	**$ (81,362)**	$ (79,622)

Amounts recorded in the interim condensed consolidated statements of operations and changes in net assets for the swaps agreements are as follows:

	For the Quarter Ended September 30,		For the Nine Months Ended September 30,		For the Year Ended December 31,
	2017	2016	**2017**	2016	**2016**
Net cash payments on interest rate swap agreements (interest expense)	**$ 2,067**	$ 2,435	**$ 6,597**	$ 7,443	**$ 9,831**
Change in the fair value of interest rate swap agreements (nonoperating)	**$ (544)**	$ 530	**$ (1,740)**	$ (25,894)	**$ 9,221**

The Interim Condensed Consolidated Financial Statements were prepared on October 16, 2017.

The interest rate swap instruments contain provisions that require Advocate to maintain an investment grade credit rating on its tax-exempt bonds from certain major credit rating agencies. If Advocate's tax-exempt bonds were to fall below investment grade on the valuation date, it would be in violation of these provisions and the counterparty to the derivative instruments could request immediate payment or demand immediate and ongoing full overnight collateralization on derivative instruments in net liability positions.

Note J – Retirement Plans

Advocate maintains defined benefit pension plans ("Plans") that cover substantially all its employees ("associates").

The interim condensed consolidated balance sheets contained a liability related to the Advocate Health Care Network Pension Plan ("Advocate Plan") of $13.9 million and $14.1 million at September 30, 2017 and December 31, 2016, respectively. In addition, the interim condensed consolidated balance sheets contain a liability related to the Condell Health Network Retirement Plan ("Condell Plan") of $5.2 million and $6.1 million at September 30, 2017 and December 31, 2016, respectively.

Pension plan expense included in the interim condensed consolidated statements of operations and changes in net assets is as follows:

	For the Quarter Ended September 30,		For the Nine Months Ended September 30,		For the Year Ended December 31,
	2017	2016	**2017**	2016	**2016**
Service cost	**$ 13,527**	$ 12,354	**$ 40,581**	$ 37,060	**$ 49,413**
Interest cost	**10,335**	10,360	**31,005**	31,080	**41,440**
Expected return on plan assets	**(17,044)**	(16,597)	**(51,132)**	(49,791)	**(66,388)**
Amortization of:					
Recognized actuarial loss	**2,660**	2,923	**7,980**	8,769	**11,690**
Prior service cost (credit)	**(1,206)**	(1,206)	**(3,618)**	(3,618)	**(4,823)**
Settlement/curtailment	-	-	**-**	-	**852**
Net pension expense	**$ 8,272**	$ 7,834	**$ 24,816**	$ 23,500	**$ 32,184**

Amounts funded into the Plans were paid from employer assets and were as follows (there were no contributions other than cash to the Plans):

	For the Quarter Ended September 30,		For the Nine Months Ended September 30,		For the Year Ended December 31,
	2017	2016	**2017**	2016	**2016**
Cash contributions	**$ 7,875**	$ 12,200	**$ 25,875**	$ 27,800	**$ 35,600**

At this time, Advocate anticipates making $32.2 million of cash contributions to the Plans during 2017. Expected associate benefit payments from the Plans' assets are $65.1 million in 2017; $69.9 million in 2018; $75.1 million in 2019; $77.1 million in 2020; $80.9 million in 2021 and $414.5 million for the years 2022 through 2026.

The Plans' asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, economic sectors and manager style to minimize the risk of loss. Advocate utilizes investment managers specializing in

each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. Advocate regularly monitors manager performance and compliance with investment guidelines.

Advocate's target and actual allocation of the Advocate Plan assets are as follows:

	Target	September 30, 2017	December 31, 2016
Domestic and International equity securities	35.0%	35.9%	36.0%
Alternative investments	45.0	45.6	46.0
Cash and fixed income securities	20.0	18.5	18.0
	100.0%	100.0%	100.0%

Assumptions used to determine benefit obligations are as follows:

	December 31, 2016
Discount rates	4.05%
Assumed rate of return on assets - Advocate Plan	7.25%
Assumed rate of return on assets - Condell Plan	5.00%

The assumed rate of return on Plan assets is based on historical and projected rates of return for asset classes in which the portfolio is invested. The expected return for each asset class was then weighted based on the target asset allocation to develop the overall expected rate of return on assets for the portfolio.

In addition to these Plans, Advocate sponsors various defined contribution plans for its associates. Contributions to these plans, which are included in salaries, wages and employee benefits expense in the interim condensed consolidated statements of operations and changes in net assets, were as follows:

	For the Quarter Ended September 30,		For the Nine Months Ended September 30,		For the Year Ended December 31,
	2017	2016	**2017**	2016	**2016**
Contribution plan expense	**$ 13,546**	$ 12,342	**$ 39,323**	$ 39,096	**$ 51,682**

Note K – General and Professional Liability Risks

Advocate is self-insured for substantially all general and professional liability risks. The self-insurance programs combine various levels of self-insured retention with excess commercial insurance coverage. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Revocable trust funds, administered by a trustee and a captive insurance company, have been established for the self-insurance programs. Actuarial consultants have been retained to determine the

estimated cost of claims, as well as to determine the amount to fund into the irrevocable trust and captive insurance company.

Advocate is a defendant in certain litigation related to professional and general liability risks, and other matters. Although the outcome of the litigations cannot be determined with certainty, management believes, after consultation with legal counsel, that the ultimate resolution of the litigations will not have a material adverse effect on Advocate's operations or financial condition.

Note L - Legal, Regulatory, and Other Contingencies

The health care industry is subject to significant regulatory requirements of federal, state and local governmental agencies and independent professional organizations and accrediting bodies, technological advances and changes in treatment modes, various competitive factors and changes in third-party reimbursement programs. Certain of these factors include: licensing, surveys, audits and investigations; privacy laws; "Fraud and Abuse" laws and regulations; the Federal False Claims Act; restrictions on referrals; environmental laws and regulations; and other Federal, state and local laws and regulations.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. During the last few years, due to nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, exclusion from the Medicare and Medicaid programs, and revocation of federal or state tax-exempt status. Moreover, Advocate expects that the level of review and audit to which it and other health care providers are subject will increase.

Various federal and state agencies have initiated investigations, which are in various stages of discovery, relating to reimbursement, billing practices and other matters of Advocate. There can be no assurance that regulatory authorities will not challenge Advocate's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have on Advocate. Thus, there is a reasonable possibility that recorded amounts will change by a material amount in the near term. To foster compliance with applicable laws and regulations, Advocate maintains a compliance program designed to detect and correct potential violations of laws and regulations related to its programs.

In March 2014, Advocate and certain of its subsidiaries were named as defendants to litigation surrounding the church plan status of one of Advocate's defined benefit plans. In December 2014, the United States District Court for the Northern District of Illinois ("District Court") issued its Decision and Order denying the Defendants' Motion to Dismiss. Advocate filed a Motion for Interlocutory Appeal, which was granted in January 2015, and subsequently filed its Petition for Appeal with the Seventh Circuit in January 2015. In March 2016, the Seventh Circuit affirmed the District Court decision. In July 2016 Advocate filed a petition with the Supreme Court of the United States seeking review of the lower courts' rulings. In December 2016, the Supreme Court agreed to hear Advocate's appeal as part of a consolidated case. Oral arguments were heard in March 2017. In June 2017, the Supreme Court of the United States ruled a pension plan maintained by a principle-purpose organization qualified as a church plan, regardless of who establishes the plan, and the case was

remanded to the Seventh Circuit. On August 14, 2017, the Seventh Circuit entered an order reversing the District Court's judgment and remanding the case to the District Court for further proceedings. A hearing was held on in the District Court on August 23, 2017, and the District Court granted a sixty-day continuance. The continuance has been extended until January 8, 2018. The next hearing is scheduled for January 11, 2018. Regardless of the outcome of further proceedings, Advocate does not believe that this matter will have a material adverse effect on Advocate's financial position or results of operations.

Note M - Affiliation and Merger

Prior to January 1, 2017, Advocate had a 50% membership and governance interest in Advocate Health Partners (d/b/a Advocate Physician Partners) ("APP") which had been accounted for on an equity basis. Advocate's carrying value, which approximated the fair value in this interest was $0 at December 31, 2016.To better align Advocate's and APP resources related to capitated and other risk arrangements the APP bylaws were amended effective January 1, 2017. The amendment resulted in Advocate obtaining a majority of board seats and certain reserve powers. Accordingly, APP's financial statements are consolidated in Advocate's financial statements as of January 1, 2017.

The fair value of assets and liabilities of APP on January 1, 2017 consisted of the following:

Cash and cash equivalents	$ 157,285
Other current assets	28,581
Total assets	$ 185,866
Current liabilities	$ 185,866

Total operating revenue and operating income from the date of consolidation for APP of $578,187 and $0, respectively have been included in the accompanying condensed consolidated statements of operations and changes in net assets for the third quarter ended September 30, 2017.

Following are the unaudited pro forma results for the year ended December 31, 2016, as if the consolidation had occurred on January 1, 2016:

Total operating revenue	$5,875,099
Operating income	$263,960
Revenues in excess of expenses	$597,604

The pro forma information provided should not be construed to be indicative of Advocate's results of operations had the consolidation been consummated on January 1, 2016 and is not intended to project Advocate's results of operations for any future period.

Note N – Subsequent Events

Advocate evaluated events occurring between July 1, 2017 and November 14, 2017, which is the date when the interim condensed consolidated financial statements were issued.

Advocate Health Care Network and Subsidiaries
Management Discussion and Analysis of Financial Condition and Results of Operations

This Management Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with the Interim Condensed Consolidated Financial Statements for the third quarter ended September 30, 2017.

Organizational Overview

Advocate Health Care Network and Subsidiaries, ("Advocate"), based in Downers Grove, Illinois, is the largest health care provider in the State of Illinois.

Advocate Health Care Network ("AHCN") is the sole member of Advocate Health and Hospitals Corporation ("AHHC") and Advocate Sherman Hospital ("ASH"). AHHC is the sole member of Advocate North Side Health Network ("North Side") and Advocate Condell Medical Center ("ACMC"). AHCN and AHHC are also the sole members of various not for profit corporations or the shareholders of various business corporations, the primary activities of which are the delivery of health care services or the provision of goods and services ancillary thereto. These controlled corporations, along with AHCN, ASH, AHHC, ACMC and North Side, constitute "Advocate." As the parent of Advocate, AHCN currently has no material operations or activities of its own, apart from its ability to control ASH, AHHC, ACMC, North Side and other controlled organizations compromising Advocate. All of Advocate's hospitals, except for Advocate Illinois Masonic Medical Center (owned by North Side), Advocate Condell Medical Center (owned by ACMC) and Advocate Sherman Hospital (owned by ASH) are owned by AHHC. Advocate's not for profit corporations, including AHCN, ASH, AHHC, North Side and ACMC, are exempt from federal income taxation pursuant to Section 501(c)(3) of Internal Revenue Code of 1986, as amended the ("Code").

Advocate provides a continuum of care through its eleven acute care hospitals and an integrated children's hospital, which in total have approximately 3,600 licensed beds, primary and specialty physician services, outpatient centers, population health management services and home health and hospice care in northern and in central Illinois. Advocate has approximately 6,300 physicians on the medical staffs of its hospitals. Through a long-term academic and teaching affiliation with the University of Illinois at Chicago Health Sciences Center, Advocate trains more resident physicians than any other non-university teaching hospital in Illinois. Additionally, through Advocate Physician Partners ("APP"), a leader in population health management, Advocate brings together approximately 5,000 physicians to improve health care quality, safety and outcomes for patients across Chicagoland and central Illinois.

Advocate makes strategic, operating and financial decisions on a system-wide basis to provide for complete financial integration of Advocate hospitals and other health services. Further, Advocate's overall management is centralized to allow for a streamlined decision making process and the ability to respond quickly to market forces. Advocate's management believes it has the greatest geographic coverage in northern and central Illinois with over 450 sites of care.

Advocate owns two large physician groups. Advocate Medical Group (”AMG”) is an unincorporated physician group that is a division of AHHC. As of September 30, 2017, AMG employed approximately 1,049 full-time equivalent (“FTE”) physicians. Dreyer Clinic Inc. (“DCI”) is an incorporated physician group and wholly owned subsidiary of Advocate. As of September 30, 2017, DCI employed approximately 156 FTE physicians. Additionally, Advocate employs approximately 465 FTE advanced practice clinicians.

Strategic Direction

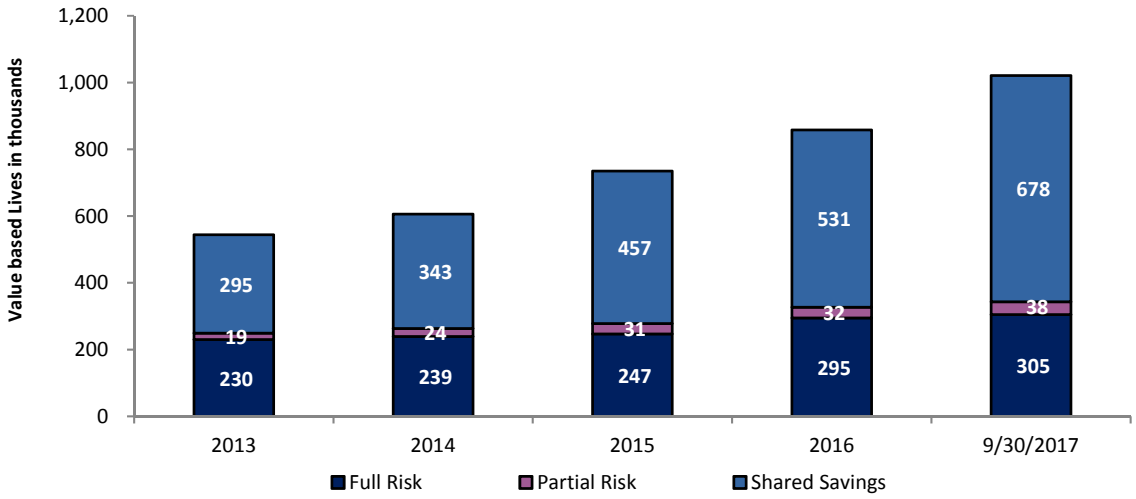
Advocate is among national industry leaders in the transformation of care delivery from fee-for-service to fee-for-value. Consistent with its mission of serving the “health needs of individuals, families and communities” Advocate has established a vision and set of strategies to become a “population health management” organization.

This strategy includes three key components:

- Aligned Physicians – Through APP, Advocate has clinically integrated with approximately 5,000 physicians, approximately 3,600 of whom are independent practitioners. APP provides single-signature contracting with payors, all of whom provide financial incentives to APP to reward physicians for improvements in quality, safety, service and cost. As a pioneer of clinical integration, Advocate has the ability to align large numbers of physicians to accept risk for improving the health of the population and for reducing the cost of care.

- Migrate Reimbursement to Value and Risk-Based Contracts – Advocate has executed contracts with commercial and governmental payors that reward the organization for quality and reducing the total cost of care. Advocate currently participates in the Medicare Shared Savings Program (“MSSP”), Medicare Advantage contracts, capitation-based contracts for several commercial health management organizations, including beginning in 2016 an exchange product, BlueCare Direct®, in collaboration with Blue Cross, which is available on the Get Covered Illinois exchange, the official Health Insurance Marketplace for individuals and families, and also a shared savings contract with Blue Cross. At September 30, 2017, covered and attributed lives for which Advocate is responsible for improving quality and reducing the total cost of care was approximately 1,021,000. Advocate is exploring additional strategies and opportunities to increase the number of enrollees it serves through risk and value-based contracts while appropriately managing financial risk.

The growth in lives from value and risk based contracts entered into by Advocate or APP is reflected in the following graph:



- Invest in Care Management and Care Coordination – Advocate believes that it has established a robust care management and care coordination capability designed to improve the health of and reduce the total cost of care for the population served. This strategy has allowed Advocate to beat market benchmarks for trend in the cost of care and to perform successfully under value and risk-based reimbursement.

Advocate foresees continued investment in its care delivery assets to ensure that safety, quality, service and cost are optimized. The creation of a tightly integrated and scaled care delivery network is a critical enabler of the population health management strategy. Advocate may also continue to invest in its network to increase access and affordability through new outpatient locations, continued growth of its employed physician group and integration of its home health, hospice and palliative care services.

Mission and Community Benefit

As a faith-based health care organization, affiliated with the United Church of Christ and the Evangelical Lutheran Church in America, the mission, values and philosophy of Advocate form the foundation for its strategic priorities. Advocate's mission is to serve the health care needs of individuals, families and communities through a holistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. Consistent with its mission, Advocate is committed to providing each patient with quality care and service and treating each patient with respect, integrity and dignity.

Consistent with the values of compassion and stewardship, the System makes a major commitment to patients in need, regardless of their ability to pay. Charity care is provided to patients who meet the criteria established under the System's financial assistance policy. Patients eligible for consideration can earn up to 600% of the federal poverty level. Qualifying patients can receive up to 100% discounts from charges and extended payment plans. Charity care services are not reported as net patient service revenue because payment is not anticipated while the related costs to provide the health care are included in operating expenses.

The cost to Advocate of providing uncompensated care to the uninsured, underinsured and unreimbursed cost of government sponsored programs for 2016 and 2015, the latest years for which the Illinois Annual Non-Profit Hospital Community Benefits Reports have been filed, is as follows:

	Year Ended December 31, (dollars in thousands)	
	2016	**2015**
Charity care	$ 56,996	$ 64,958
Uncollectible accounts	79,258	62,235
Unreimbursed government sponsored indigent health care	380,338	390,085
Total Costs of Uncompensated Care	$ 516,592	$ 517,278

The total cost of uncompensated care represents the largest portion of the total of all community benefits provided by Advocate. Total uncompensated care costs decreased from 2015 to 2016 primarily due to the higher Medicaid expansion funds received in 2016. See Management's Discussion of Financial Performance - Medicaid Assessment Systems for details of payments received. One of the objectives of The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "ACA"), has been to extend the availability and affordability of health care insurance to those segments of the population who have not been able to afford health care insurance or who have not had access to health care services.

Advocate is involved in numerous activities and programs reaching beyond the walls of its hospitals and into the community. These activities are wide-ranging and include providing community health education, immunizations for children and seniors, support groups, health screenings, health fairs, pastoral care and parish nursing, home-delivered meals, transportation services, seminars and speakers, community meeting space, crisis lines, spirituality newsletters, newspaper and magazine articles regarding current health issues, medical residency and internships, education to other health professionals such as nurses and pharmacy technicians, research and language assistance, dental van for special needs patients, counseling for hospice patients and their families, and many other subsidized health services. The cost of these programs and activities are provided either free of charge or for a fee less than the cost of providing them. The cost of providing these other community benefits totaled $175.1 million in 2016.

Further, the ACA resulted in the creation of Section 501(r) of the Code, described below, which imposes requirements on tax-exempt hospitals to develop, implement and monitor charity care policies and procedures. Section 501(r) affects 501(c)(3) organizations that operate one or more hospital facilities ("Hospital Organizations"). In 2014, the IRS issued final regulations under Section 501(r) to clarify certain requirements of Section 501(r) (the "501(r) Regulations"), which became effective for tax years beginning after December 29, 2015, calendar year 2016 for Advocate. Pursuant to Section 501(r) of the Code, each Hospital Organization is required to meet four general requirements on a facility-by-facility basis:

- establish written financial assistance and emergency medical care policies;
- limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy;
- make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual; and
- conduct a community health needs assessment ("CHNA") and adopt an implementation strategy at least once every three years.

These requirements affect almost every aspect of a hospital organization's operations, including patient intake, financial counseling, the emergency room, information technology, billing, collections, public relations, community outreach, finance and accounting, legal, and tax reporting.

Section 501(r) provides penalties applicable to hospital organizations that fail to comply with any of the requirements of Section 501(r). Among these are:

- Excise tax ($50,000 per facility) for failure to meet CHNA Requirements
- Potential revocation of status as an exempt organization under 501(c)(3) of the Code
- Potential taxation of noncompliant hospital facilities

Under the CHNA requirement, if an omission or error is minor and either inadvertent or due to reasonable cause and if the hospital facility corrects the omission or error such a minor omission or error may not give rise to an excise tax. When determining whether to revoke a tax-exempt organization's status under Section 501(c)(3) of the Code as a result of a failure to meet one or more requirements of Section 501(r), the Internal Revenue Service (the "IRS") will consider all relevant facts and circumstances. For hospital organizations operating one or more hospital facilities, the failure of one or more hospital facilities to comply with Section 501(r) will not jeopardize the hospital organization's tax-exempt status. Instead, the noncompliant hospital facility's income will be treated as taxable during the applicable tax year. The 501(r) Regulations also prohibit the ability of a hospital organization to aggregate such taxable income with other unrelated business activities that might generate offsetting losses. The 501(r) regulations provide that the imposition of such tax on a hospital facility will not itself cause the interest on any applicable tax-exempt bonds to be taxable.

Management believes that Advocate has been operating in compliance with Section 501(r) since January 1, 2016.

Employees

As of September 30, 2017, Advocate employed approximately 36,800 individuals (approximately 31,000 FTEs). Advocate's management believes that the salary levels and benefits packages for its employees ("associates") are competitive and that Advocate's managers generally have good relationships with their associates. Less than one tenth of one percent (0.1%) of Advocate associates are represented by collective bargaining groups.

Advocate, along with other healthcare providers, has been the target of unions attempting to organize associates. Unions have employed various tactics to either directly attract associates or engage in corporate campaign strategies that are designed to undermine the credibility and integrity of the targeted health care providers.

On September 27, 2016 Advocate was notified that the Regional National Labor Relations Board ("RNLRB") issued a complaint against AMG. In its complaint, the RNLRB supported the claim of the Illinois Nurses Association ("INA") that AMG improperly refused to recognize and bargain with the INA relative to a group of approximately 150 AMG Advanced Practice Nurses, who represent approximately five-tenths of one percent (0.5%) of all Advocate associates. On August 24, 2017, the United States District Court for the Northern District of Illinois Eastern Division ruled Advocate was a successor employer by virtue of its acquisition of Advocate Clinic at Walgreens. Consistent with this ruling, Advocate has commenced contract negotiations with the INA.

On October 13, 2017, the Teamsters Local 743 (Teamsters) filed a petition with the NLRB to represent Housekeeping, Food and Nutrition and Transportation (section of non-professionals) employees at Advocate Christ Medical Center. On October 17, 2017, the Teamsters withdrew the petition.

Management cannot predict with any certainty whether this complaint or any union organizing related activities will have any material adverse effect on the financial condition or operations of Advocate.

In recent years, the health care industry has suffered from a scarcity of nursing and other qualified health care technicians and personnel. This trend is now resulting in Advocate having to pay higher salaries to nursing and other qualified health care technicians and personnel as competition for such employees has intensified.

Summary of Significant Accounting Policies and Use of Estimates

Advocate's accounting policies are fundamental to understanding management's discussion and analysis of results of operations and financial condition. Many of Advocate's accounting policies require significant judgment regarding valuation of assets and liabilities and/or significant interpretation of specific accounting guidance. Advocate's significant accounting policies are described in Note 1 of Advocate's 2016 audited consolidated financial statements and are summarized in the notes to the Interim Condensed Consolidated Financial Statements for the third quarter ended September 30, 2017. There have been no significant changes in accounting policies from the 2016 audited consolidated financial statements. Refer to Notes B and C of the notes to the Interim Condensed Consolidated Financial Statements for the third quarter ended September 30, 2017 for information related to the adoption of new accounting standards and the use of estimates, respectively. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Although estimates are considered to be reasonable at the time made, actual results could differ materially from those estimates.

Internal Control Environment

Advocate has an independent Audit Committee of the Board of Directors and an Internal Audit Department. Advocate has adopted the Committee of Sponsoring Organizations of the Treadway Commission Internal Control – Integrated Framework (2013). The Internal Audit Department carries out an annual audit program that assesses Advocate's design and operation of internal controls to achieve efficient and effective

operations, accurate and reliable financial reporting, compliance with policies, laws and regulations, and the proper safeguarding of assets.

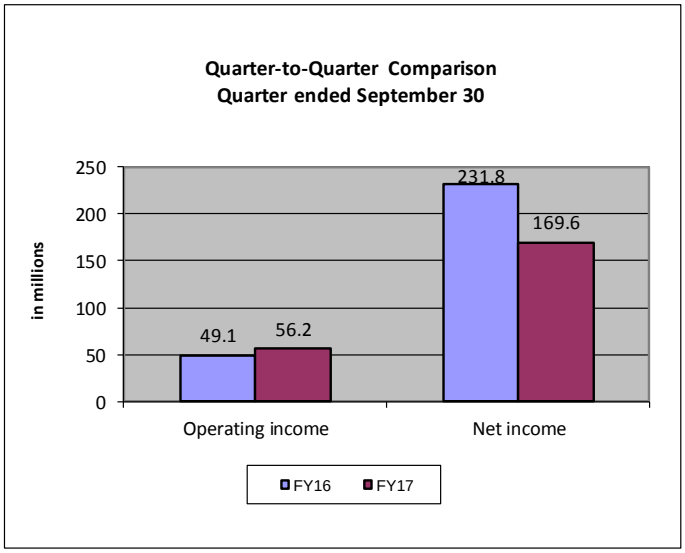
General Economic Conditions

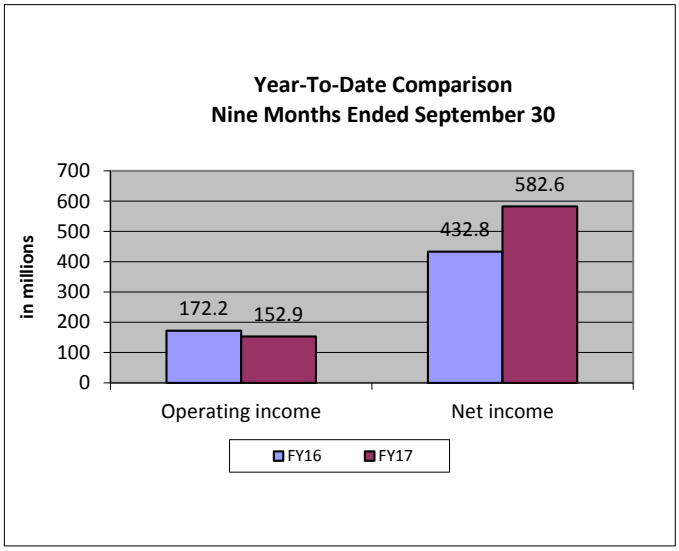
The health of the economy has a direct impact on Advocate. Hospitals continue to feel the impact of underemployment, reduced personal income earning expectations, diminished access to private insurance and high deductible plans and coinsurance levels. Unemployment remains high within the service areas in which Advocate operates and in certain of those areas remains higher than the national average. Budget pressures have impacted the State of Illinois, resulting in more stringent standards and delays of payment amounts due under Medicaid and other state or local payment programs.

Effects of a weaker economy on hospitals and physician practice operations have also resulted in (but are not limited to) lower patient volumes as patients defer elective health care services; rising charity care and bad debt expense; budget pressures on federal and state governments intensifying reviews of Medicare and Medicaid reimbursement rates; unfavorable changes in payor mix away from commercial payors; financial pressures and decreasing membership at health care insurers, contributing to lower commercial rate increases for health care providers; and increased difficulty attracting philanthropy.

Results of Operations

Quarter-to-quarter and year-to-date comparison of payor mix and utilization information is included in Attachment 1 of this document. Set forth below is the quarter-to-quarter comparison of operating and net income.





Medicaid Assessment and ACA Related Systems:

In 2008 the Centers for Medicare & Medicaid Services ("CMS") approved a Medicaid assessment system, and in 2013 CMS approved an enhanced Medicaid assessment system, each of which is scheduled to be in effect through September 30, 2018. Net proceeds from these two programs amounted to $42.1 million and $44.4 million for the nine months ended September 30, 2017 and 2016, respectively, and $58.4 million for the year ended December 31, 2016. In the Interim Condensed Consolidated Statements of Revenues and Expenses and Changes in Net Assets, proceeds from these two assessment systems of are included as part of net patient service revenue and related assessment expenses as part of the Medicaid Assessment statement line in the Expenses section.

In January 2015 CMS approved as part of the ACA providing the State of Illinois with funds retroactive to March 2014 to assist Illinois hospitals with the expansion of Medicaid. The amount received will increase or decrease depending on the growth of Medicaid in the State of Illinois. Advocate received approximately $29.3 million and $22.9 million in expansion funds in the nine months ended September 30, 2017 and 2016, respectively, and $31.4 million for the year ended December 31, 2016. Expansion fund proceeds are included in net patient service revenue in the Interim Consolidated Statements of Revenues and Expenses and Changes in Net Assets.

On May 31, 2016 the State of Illinois passed HB 4678 which implemented a framework to increase ACA access funds to Illinois hospitals. The new ACA access funds are attributable to the ACA adults enrolled in managed care products. In September 2016, the Illinois Department of Family and Healthcare Services submitted its certification of the new Medicaid managed care organization rates to CMS. The increase in net ACA access funds to Advocate hospitals, which was retroactive to January 1, 2016, is projected to be approximately $67.0 million for the period of January 1, 2016 to September 30, 2018. Net proceeds recognized for ACA access funds were $18.5 million and $23.3 million for the nine months ended September 30, 2017 and 2016, respectively, and were $36.3 million for the year ended December 31, 2016. The gross proceeds from the ACA access funds are included in net patient service revenue and related assessment expenses are included as part of the Medicaid Assessment statement line in the Expenses section in the Interim Consolidated Statements of Revenues and Expenses and Changes in Net Assets.

Each of these programs expire on September 30, 2018. A summary of assessment programs, ACA expansion funds and ACA access funds proceeds and related expenses are as follows:

	For the quarter ended September 30,		For the nine months ended September 30,		For the year ended December 31,
	2017	2016	2017	2016	2016
Assessment Programs:					
Revenues	71,782	86,361	211,597	201,000	275,740
Expenses	40,721	39,292	121,736	110,396	149,609
Net benefit	31,061	47,069	89,861	90,604	126,131

Consolidation of Advocate Physician Partners:

To further align APP and Advocate, the APP and Advocate Boards of Directors approved revisions to the APP bylaws that provided Advocate more than 50% of the board seats which resulted in the consolidation of APP into Advocate financial statements beginning January 1, 2017. Prior to January 1, 2017, Advocate had a 50% membership and governance interest in APP, which was accounted for on an equity basis. Advocate's carrying value in this interest was $0 at December 31, 2016. Effective January 1, 2017, net patient service revenue generated by Advocate hospitals, medical groups and other operations associated with capitated arrangements contracted by APP are eliminated in consolidation. Correspondingly, any contracted medical services incurred by APP to Advocate's hospitals, medical groups and other operations for services rendered to members under these arrangements are also eliminated. For the first nine months of 2017 this amounted to $250.1 million.

Quarters Ended September 30, 2017 and 2016:

Operating income of $56.2 million was generated during the third quarter of 2017, an increase of $7.2 million from the comparable period of 2016. The increase in operating income was due to higher inpatient volumes and increases in payment rates partially offset by higher operating costs (inflationary increases in salary -and wages and pharmaceutical costs). The operating margin was 3.6% for both of the quarters ended September 30, 2017 and September 30, 2016, and was 4.7% for the year ended December 31, 2016.

Total revenue for the third quarter of 2017 of $1,554.0 million increased $188.7 million (13.8%) from the comparable period of the prior year. Patient service revenue, net of the provision for uncollectible accounts, was $1,114.7 million for the third quarter of 2017, a decrease of $67.7 million (-5.7%) from the comparable period of the prior year. The decrease is a result of the elimination of $81.6 million of revenues associated with members of APP capitated contracts cared for at Advocate facilities. Excluding the impact of the elimination of the net patient service revenue associated with the APP capitated contracts, patient service revenue, net of the provision for uncollectible accounts, increased $13.9 million or 1.2% when compared to the third quarter of 2016. The increase reflects higher admissions and medical group visits, modest rate increases higher patient acuity, and a decrease in the provision for uncollectible accounts, partially offset by lower hospital outpatient visits, Medicaid Assessment and ACA Related Systems funds and higher charity care. Capitation revenue, which amounted to $332.0 million, increased $220.9 million for the third quarter of 2017 compared to the third quarter of 2016. The increase in capitation revenue is primarily due to the consolidation of APP into Advocate effective January 1, 2017 ($162.7 million) as well as an increase in membership participating in capitated plans primarily related to the new BlueCare Direct® product which premiered on January 1, 2016 and at September 30, 2017 had approximately 68,000 members compared to 52,000 at September 30, 2016.

Total expenses for the third quarter of 2017 amounted to $1,497.8 million, an increase of $181.5 million (13.8%) from the third quarter of 2016. Excluding APP, total expenses would have been $1,416.2 million for the third quarter 2017, a 7.6% increase compared to the third quarter of 2016. The increase in operating expenses reflects inflationary increases, and increased salaries, wages and employee benefits costs, contracted medical services, and insurance, partially offset by focused expense management. The increase in salaries, wages and employee benefits costs was due to an increase in staffing related to increased hospital inpatient and medical group volumes and an approximately one-time charge of $10 million for associates accepting an early retirement incentive plan offer. Contracted medical services of $156.3 million increased $114.7 million compared to the third quarter of 2016 primarily due to the addition of APP ($81.6 million) and an increase in membership

associated with the new BlueCare Direct® product. Insurance expense, which is included in Other, was higher as the decrease in prior year related self-insurance professional and general liability reserves was lower in 2017 compared to 2016. Depreciation and amortization increased by $2.4 million due the continued reinvestment in equipment and facilities. Interest expense of $14.9 million increased $0.6 million compared to the third quarter of 2016 primarily due to higher interest rates paid on variable rate debt and a decrease in capitalized interest due to the completion of several large projects during 2016.

Net income amounted to $169.6 million in the third quarter of 2017, a decrease of $62.2 million from the comparable period of 2016. This resulted in a net margin of 10.5% for the quarter ended September 30, 2017 compared to a net margin of 15.0% for the quarter ended September 30, 2016 and 10.1% for the year ended December 31, 2016. The decrease in net income is primarily due to lower investment returns in the third quarter of 2017 compared to the third quarter of 2016.

Nine months Ended September 30, 2017 and 2016:

Operating income of $152.9 million was generated during the first nine months of 2017, a decrease of $19.3 million from the comparable period of 2016. The decrease was primarily due to the decrease of $16.5 million in APP incentive funds recorded in the nine months of 2017 compared to the first nine months of 2016. In addition, the decrease in operating income is due to lower outpatient visits of 0.5%, and higher operating costs (inflationary increases in salary -and wages and pharmaceutical costs) not offset by increases in payment rates. Although capitation revenues from the BlueCare Direct® exceeded medical costs, the plan membership is actuarially estimated to be healthier than membership in other exchange products in the State of Illinois, a risk transfer payment liability was accrued resulting in the loss on the BlueCare Direct® product in 2016. Significant percentage increases in per member/per month premiums for 2017 have been received resulting in a net gain of $3.9 million on the Blue Cross Direct product for the nine months ended September 30, 2017. Management cannot predict whether this product will have a material impact on the operating results, cash flow and financial condition of Advocate in 2017 or future years. See “Managed Care and Capitation” starting on page 37 for more information on the BlueCare Direct® product. The operating margin for the nine months ended September 30, 2017 was 3.3% compared to an operating margin of 4.1% for the nine months ended September 30, 2016 and 4.7% for the year ended December 31, 2016.

Total revenue for the first nine months of 2017 of $4,617.2 million increased $458.1 million (11.0%) from the comparable period of the prior year. Patient service revenue, net of the provision for uncollectible accounts, was $3,359.0 million for the first nine months of 2017, a decrease of $202.3 million (-5.7%) from the comparable period of the prior year. The decrease is a result of the elimination of $250.1 million of revenues associated with members of APP capitated contracts cared for at Advocate facilities. Excluding the impact of the elimination of the net patient service revenue associated with the APP capitated contracts, patient service revenue, net of the provision for uncollectible accounts, increased $47.7 million or 1.3% when compared to the third quarter of 2016. The increase reflects higher admissions and medical group visits, higher Medicaid Assessment and ACA Related Systems funds, modest rate increases, higher patient acuity, and a decrease in the provision for uncollectible accounts, partially offset by lower hospital outpatient visits and higher charity care. Capitation revenue, which amounted to $976.9 million, increased $610.9 million for the first nine months of 2017 compared to the first nine months of 2016. The increase in capitation revenue is primarily due to the consolidation of APP into Advocate effective January 1, 2017 ($496.9 million) as well as an increase in membership participating in capitated plans primarily related to the new BlueCare Direct® product which

premiered on January 1, 2016 and at September 30, 2017 had approximately 68,000 members compared to 52,000 at September 30, 2016.

Total expenses for the first nine months of 2017 amounted to $4,464.3 million, an increase of $477.3 million (12.0%) from the first nine months of 2016. Excluding APP, total expenses would have been $4,214 million for the first nine months of 2017, a 5.7% increase compared to the first nine months of 2016. The increase in operating expenses reflects inflationary increases, and increased salaries, wages and employee benefits costs, contracted medical services, and Medicaid Assessment and ACA Related Systems Tax, partially offset by focused expense management. The increase in salaries, wages and employee benefits costs was due to an increase in staffing related to increased hospital inpatient and medical group volumes and an approximately one-time charge of $10 million for associates accepting an early retirement incentive plan offer. Contracted medical services of $435.9 million increased $284.3 million compared to the first nine months of 2016 primarily due to the addition of APP ($250.1 million) and an increase in membership associated with the new BlueCare Direct® product. Depreciation and amortization increased by $12.0 million due the continued reinvestment in equipment and facilities. Interest expense of $44.4 million increased $3.9 million compared to the first nine months of 2016 primarily due to higher interest rates paid on variable rate debt and a decrease in capitalized interest due to the completion of several large projects during 2016.

Net income amounted to $582.6 million in the first nine months of 2017, an increase of $149.7 million from the comparable period of 2016. This resulted in a net margin of 11.6% for the nine months ended September 30, 2017 compared to a net margin of 9.8% for the nine months ended September 30, 2016 and 10.1% for the year ended December 31, 2016. The increase in net income is primarily due to higher investment returns in the first nine months of 2017 compared to the first nine months of 2016.

Due to upward pressures on operating costs, Management has undertaken initiatives to reduce annual operating expenses by approximately $185 million. Management believes financial pressures emanate from:

1. Reimbursement rates from federal and state government that do not cover the costs to care for patients;
2. An increasing number of patients enrolling in those very same federal and state programs;
3. Significant increases in both charity care and bad debt; and
4. Reimbursement rates from commercial insurance carriers that are less than inflationary cost increases in pharmaceutical and salary and wage costs.

Management believes a transformation in the delivery of healthcare will be required to solve this situation that will take months or longer to complete. To begin addressing, Management put in place certain initial actions including a hiring freeze on non-clinical positions and a freeze on certain capital spending. A thorough review of all programs and services, as well as the organizational structure was undertaken. Management has identified and has started to implement changes around the delivery of services, organizational structure and the operations of programs, which affect both revenues and expenses, to meet the $185 million target. In connection with this process, an early retirement incentive plan was offered to associates meeting certain criteria and their positions were permanently eliminated. An approximately one-time charge of $10 million to operations was incurred in the third quarter and is in included in Salaries and Wages and Employee Benefits in the Interim Consolidated Statements of Revenues and Expenses and Changes in Net Assets. The

decisions to change or eliminate programs, services and jobs is being guided by Advocate's Mission, Values and Philosophy, and every decision is reinforcing that Advocate is first and foremost a safe, clinical enterprise.

General and Professional Liability Insurance

Advocate has a comprehensive insurance program designed to conserve and protect its assets and properties. Risk transfer is utilized to shift exposures and losses to a third-party indemnifier when it is deemed prudent and appropriate. Certain components of the insurance program, including hospital professional and general liability risks, are self-insured on a claims-made basis. Advocate purchases excess liability insurance in amounts it deems necessary to cover losses that may exceed its self-insured portion. Limits of excess liability insurance are commensurate with health care industry standards and are placed with insurance carriers that Advocate believes are currently financially sound.

Actuarial consultants are retained to determine funding requirements as well as to assist in the estimation of outstanding general and professional liabilities for retained risks. Accruals for general and professional liability claims are actuarially determined using a discount rate of 3.0% as of September 30, 2017 and December 31, 2016. The estimated cost of claims is actuarially determined based on experience as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance and claims costs would have been approximately $38.1 million greater at December 31, 2016 had these liabilities not been discounted. Advocate targets to fund its total discounted accrued self-insured general and professional liabilities into an irrevocable trust that is administered by a bank trustee and a captive insurance company.

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts.

Advocate maintains commercial insurance policies for additional lines of coverage relevant to the operation of an integrated health care delivery system. Some policies carry deductibles. All insurance coverage, lines and self-insured programs have been reviewed annually by an independent insurance auditor.

Independent physicians that are credentialed to be a member of an Advocate hospital medical staff must maintain specified insurance levels to practice at Advocate hospitals. Costs of general and professional liability claims can make it difficult for physicians to maintain such coverage. These market forces may exert further upward pressure on Advocate's insurance expense and/or affect its relations with medical staff members.

Advocate is a defendant in certain litigation related to professional and general liability risks. Although the outcome of the litigation cannot be determined with certainty, management believes, after consultation with legal counsel, that the ultimate resolution of this litigation will not have any material adverse effect on Advocate's operations or financial condition.

Liquidity and Capital Resources

Unrestricted cash and investment balances (including amounts reported as part of assets limited to use, and investments under securities lending program) was $5,328.8 million at September 30, 2017 and $4,962.0 million at December 31, 2016. Attachment 2 of this report provides a summary of available liquidity at September 30, 2017.

Days cash and investments on hand were 353 as of September 30, 2017, a decrease of 17 days from December 31, 2016. The decrease is primarily attributable to the consolidation of APP into Advocate on January 1, 2017 and an increase in overall operating expenses, partially offset by strong investment returns.

As described in Note G, at September 30, 2017, Advocate had lines of credit with banks aggregating $325.0 million. These lines of credit provide for various interest rates, payment terms and currently expire as follows: $100.0 million in March 2018, $100.0 million in August 2018 and $100.0 million in December 2019, and $25.0 million in August 2020. These lines of credit may be used to redeem or purchase bonds, pay costs related to such redemptions or purchases, for capital expenditures or for general working capital purposes. Management currently intends to request that the banks renew these agreements prior to expiration. At both December 31, 2016 and September 30, 2017 and from October 1, 2017 through the date of this document, there were no amounts drawn on these lines of credit.

Net capital expenditures amounted to $269.7 million and $303.8 million for the nine months ended September 30, 2017 and 2016, respectively. The capital expenditures in 2016 and 2017 primarily reflect expenditures made towards bed tower projects on two of the hospital campuses and new ambulatory sites. Capital spending in 2016 and 2017 was financed by unrestricted cash and investments, cash generated from operations and proceeds from the Series 2015 bond issuance.

In the fourth quarter of 2016, Advocate's Board of Directors authorized approximately $213 million of new capital spending. This capital spending authorization includes amounts for various infrastructure improvement, clinical technology, information technology projects and routine capital needs. Management anticipates funding these additional projects from unrestricted cash and investments.

As described in Note G, Advocate is a party to four separate standby bond purchase agreements (the "SBPAs") with three banks to provide liquidity support for the four subseries of the Series 2008C Bonds (other than the $22.0 million Series 2008 C-3B Bonds, which were converted to long-term rate bonds in 2009) in the event of a failed remarketing of any of such subseries of the Series 2008C Bonds. The SBPAs require various reporting, operating and financial covenants to be maintained. These covenants may be waived, modified or amended by the bank in its sole discretion and without notice to or consent by any bond trustee, the Master Trustee or the holders of any outstanding bonds. Violation of any of such covenants may result in an Event of Default under the Advocate Master Indenture, which could result in acceleration of all Obligations issued under the Advocate Master Indenture. Unless extended, the SBPA for the Series 2008C-1 Bonds will terminate on August 31, 2020 the SBPA for the Series 2008C-2A Bonds will terminate on August 1, 2019 and the SBPAs for the Series 2008C-2B Bonds and the Series 2008C3-A Bonds will terminate on August 15, 2021. In the event that any Bank Bonds are not remarketed within one year from the date they are purchased by a bank pursuant to an SBPA, Advocate has agreed to cause such Bank Bonds to be redeemed pursuant to the related bond indenture such that the unpaid principal balance of all then outstanding Bank Bonds shall amortize in sixteen approximately equal quarterly installments, with the first installment commencing on the date that is one year and one day after the date on which such Series 2008C Bond became a Bank Bond, and the final installment payable on the date that is five years from the date on which such Series 2008C Bond became a Bank Bond. At December 31, 2016, September 30, 2017 and the date of this report, there were no Bank Bonds outstanding.

Advocate is party to additional covenants agreements (the "CAs") with a bank, relating to the $50 million Series 2011C Bonds and $50 million Series 2011D Bonds issued in September 2011 and purchased by a bank. The CAs require various reporting, operating and financial covenants to be maintained. These covenants may be waived, modified or amended by the bank in its sole discretion and without notice to or consent by any bond trustee, the Master Trustee or any holders of outstanding bonds. Violation of any of such covenants may result in an Event of Default under the Advocate Master Indenture, which could result in acceleration of all Obligations issued under the Advocate Master Indenture. The Series 2011C Bonds and Series 2011D bonds currently bear interest at an indexed rate until September 3, 2024. At the end of their initial periods, the Series 2011C Bonds and the Series 2011D Bonds will be subject to mandatory tender, unless waived by the holders thereof, and Advocate presently anticipates that the Series 2011C Bonds and Series 2011D Bonds will be remarketed to new holders in one of the interest rate modes available under the related bond indenture. In the event the Series 2011C Bonds or the Series 2011D Bonds are not remarketed on their respective mandatory tender dates, then, as long as no default or event of default (as defined in the CAs) has occurred and is continuing, the Series 2011C Bonds or Series 2011D Bonds, as applicable, may either be repaid over a three-year period or remarketed during that time.

The Series 2003A and the Series 2003C Bonds and the Series 2008A-1, Series 2008A-2 and Series 2008 A-3 Bonds were originally issued as long term rate bonds with stated sinking fund redemptions through 2022 and 2030, respectively. On May 1, 2012, a portion of the Series 2008A-3 Bonds ($42.8 million) was remarketed at a premium for a new seven-year interest rate period and the remaining principal amount of the Series 2008A-3 Bonds ($8.4 million) was retired. On January 24, 2013, a portion of the Series 2008A-1 Bonds ($42.0 million) was remarketed at a premium for a new seven-year interest rate period and the remaining principal amount of the Series 2008A-1 Bonds ($9.1 million) was retired. On February 1, 2013, a portion of the Series 2008A-2 Bonds ($35.5 million) was remarketed at a premium for a new seven-year interest rate period and the remaining principal amount of the Series 2008A-2 Bonds ($7.7 million) was retired. On May 5, 2016, the outstanding Series 2003C Bonds ($16.7 million) were remarketed for a new approximately six-year interest rate period that extends to their maturity date. On July 21, 2016, the Series 2003A Bonds in the amount of $17.4 million were remarketed to their final maturity date of November 15, 2022. On July 25, 2017, the Series 2008C-3B Bonds in the amount of $22.0 million were remarketed for a new one year interest period and are next subject to mandatory tender on July 30, 2018.

As described in the preceding paragraph, certain of Advocate's outstanding bonds bear interest at long term rates for a particular interest rate period, and are subject to mandatory tender at the end of each particular interest rate period. The following table summarizes the next scheduled mandatory tender dates for these bonds as of the date of this document. In the event these bonds are not remarketed upon mandatory tender at the end of their current interest rate period, management anticipates utilizing marketable unrestricted investments and/or available lines of credit to meet the purchase obligations.

Series	Principal Amount	Next Mandatory Tender Date
Series 2008C-3B	$22.0 million	July 30, 2018
Series 2008A-3	$42.8 million	May 1, 2019
Series 2008A-1	$42.0 million	January 15, 2020
Series 2008A-2	$35.5 million	February 12, 2020

The Series 2008C-3B Bonds were classified as current liabilities as of September 30, 2017 and December 31, 2016 in the interim condensed consolidated balance sheets because these bonds were subject to mandatory tender within one year of the balance sheet date.

The Series 2011B Bonds issued for Advocate's benefit in September 2011 bear interest at Windows Interest Rates (the "Windows Variable Rate Bonds") and are subject to optional and mandatory tender for purchase. The Windows Variable Rate Bonds are not supported by any external dedicated liquidity facility. Holders of Windows Variable Rate Bonds have a right to optionally tender their Bonds for purchase. If the tendered Windows Variable Rate Bonds are not successfully remarketed within the 30-day period that follows the date that notice of such optional tender is received by the Remarketing Agent (the "Remarketing Window"), then all Windows Variable Rate Bonds are required to be purchased on the day that is 210 days after notice of such optional tender is received by the Remarketing Agent (the "Windows Mandatory Tender Date"). The period from the end of the Remarketing Window until the Windows Mandatory Tender Date (initially, 180 days) is referred to as the "Funding Window." During the Funding Window, Advocate expects that it would analyze the then current market conditions, availability and relative cost of any refinancing or restructuring alternatives for those Windows Variable Rate Bonds that are required to be purchased on the Windows Mandatory Tender Date (including, without limitation, conversion of those bonds to another interest mode or the refinancing or repayment of those bonds). The Windows Variable Rate Bonds are classified as current liabilities in the interim condensed consolidated balance sheets.

Under regulatory rules of the State of Illinois, Advocate is required to post a letter of credit or a surety bond with a State agency to operate a self-insured workers' compensation program. At December 31, 2016, Advocate held a letter of credit in the amount of $19.3 million. In July 2017, Advocate replaced the letter of credit with a surety bond in the amount of $19.5 million. A separate letter of credit related to Advocate Condell Medical Center's self-insured workers' compensation program was outstanding at both September 30, 2017 and December 31, 2016 in the amount of $0.1 million. ASH had letter of credit agreements totaling $0.6 million and $1.4 million at September 30, 2017 and December 31, 2016, respectively, related to various construction projects. No amounts were drawn on these letters of credit as of December 31, 2016, September 30, 2017 or the date of this report.

Management believes that Advocate's financial condition is generally good. Advocate's cash, other liquid assets, operating cash flow, borrowing capacity and ability to lease real estate and medical equipment, taken together are believed to provide adequate resources to fund ongoing operating requirements, debt service and maintenance capital requirements.

Investment Program

Advocate's Board of Directors has adopted an investment policy that regulates the allocation of substantially all of Advocate's investment assets and further defines investment vehicles utilized among other guidelines. The allocation of assets in the investment portfolio reflects management's assessment of projected investment market environment as well as the capital and working capital requirements, earning power and debt structure of Advocate.

The investment program's target asset allocation, excluding cash and cash equivalents maintained for operating purposes, provides for a commitment to equity securities (30%), fixed income investments (25%), and select alternative investment classes (45%). For each of the above categories, the policy establishes allocation

targets, with specific ranges for each asset class, among the following investment styles: 15% domestic equities; 15% international equities; 25% fixed income; 10% private equity; 20% hedge funds; and 15% real assets. Further, limitations are placed on investment managers as to the overall amount that can be invested in one issuer (except for U.S. government obligations and its agencies) or economic sector. Assets of the program are managed by several external investment professionals. Further, Advocate utilizes the services of independent investment consultants to assist in the evaluation of the performance of investment managers and the total portfolio.

At September 30, 2017, Advocate had approximately 29% of its investment assets invested in domestic and international equities, 20% in fixed income, 12% in private equity, 31% in hedge funds and 8% in cash and cash equivalents. The overall yields (not annualized) on Advocate's investment portfolio for the quarters ended September 30, 2017 and 2016 were 2.4% and 3.4%, respectively; for the nine months ended September 30, 2017 and 2016 were 8.8% and 7.1%, respectively; and for the year ended December 31, 2016 was 7.8%.

Investment income (including both realized and unrealized gains on investments) significantly impacts Advocate's financial results. Market fluctuations have affected and will likely continue to materially affect the value of those investments and those fluctuations may be and historically have been material. Reduction in investment income, or realized and unrealized losses, and the market value of its investments may have a negative impact on Advocate's financial condition, including its ability to provide its own liquidity for variable rate debt or to fund capital expenditures from cash and investments.

Managed Care and Capitation Revenue

Managed care payors accounted for approximately 47% of net patient service revenue for the nine months ended September 30, 2017. Advocate finalized a two-year contract for the period January 1, 2015, through December 31, 2017, with a significant payor, Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois ("Blue Cross"), which represented approximately 26% of Advocate's net patient service revenue for the nine months ended September 30, 2017.

As a result of the consolidation of APP into Advocate beginning on January 1, 2017, revenues from capitated agreements directly contracted by APP are now reported as part of Advocate's capitation revenue. At September 30, 2017 revenue from capitation agreements comprised 21% of total operating revenue compared to 9% in 2016. The increase is attributed to growth in membership and the consolidation of APP into Advocate financial statements.

Advocate is a party to a capitated physician provider agreement with Humana Health Plan, Inc. and Humana Insurance Company and their affiliates ("Humana"). The commercial and Medicare HMO products of this capitated agreement are with Advocate's wholly owned medical groups and also include Humana's Medicare PPO product, which is reimbursed fee-for-service. Advocate also has hospital agreements and PPO arrangements with Humana. All agreements automatically renew for one-year terms commencing on each January 1 unless either party provides a notice of termination or notice to renegotiate the rates. All the agreements were automatically renewed for 2017. Capitation revenue received under the commercial and Medicare HMO agreements with Humana amounted to 20% and 37% of total capitation revenue for the nine months ended September 30, 2017 and 2016, respectively, and 37% for the year ended December 31, 2016.

On January 1, 2016 Advocate, in collaboration with Blue Cross of Illinois, launched a high-performance network exchange product, BlueCare Direct®. Capitation revenue received under this agreement amounted to 18% and 15% of total capitation revenue for the nine months ended September 30, 2017 and 2016, respectively, and 14% for the year ended December 31, 2016. BlueCare Direct® provides members with access to Advocate's Chicago area hospitals, a children's hospital with two campus locations, home health and hospice services, one of the region's largest medical groups and more than 5,000 Advocate primary care and specialty physicians. Membership at September 30, 2017 approximated 68,000 lives. As reported above, the BlueCare Direct® product incurred a gain of $3.9 million for the nine months ended September 30, 2017 and a loss of $39.8 million for the year ended December 31, 2016. The loss in 2016 resulted from the recognition of a risk transfer payment liability under the provisions of the ACA.

For the quarter ended September 30, 2017, membership through shared savings and risk based contracts with commercial and governmental payors with Advocate amounted to approximately 1,021,000 covered and attributed lives. These contracts are designed to improve quality and reduce the total cost of care.

Contracts with other managed care payors are generally no more than two years in length and subject to automatic renewal, renegotiation or termination at end of term.

Contact renewals are not guaranteed as they are subject to negotiation between Advocate and the managed care organization. Advocate cannot predict with any certainty the ultimate outcome of future negotiations with managed care payors as contracts expire. As of the date of this document, there are no managed care contracts under termination notice.

Management anticipates that healthcare reform will continue to alter the commercial health care insurance industry either directly through regulation or the cost shifting to employees/consumers. The ACA imposes, over time, increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the ACA imposes many new obligations on states related to health care insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect Advocate. While Congress has taken certain steps to repeal or substantially amend the ACA, these efforts have so far not succeeded. Whether Congress will in the future have sufficient votes to repeal or change the ACA, and/or pass a replacement plan is unclear. The effects of any such change to the ACA on either the financial condition of any third-party payor that offers health care insurance, the rates paid by third-party payors to providers, and the related revenues of Advocate, or on the operations, results of operations and financial condition of Advocate cannot be predicted.

Swaps and Other Financing Arrangements

Interest Rate Swaps:

As described in Note H, Advocate entered into multiple floating-to-fixed interest rate swap arrangements with respect to the Series 2008C Bonds (collectively, the "Series 2008C Swaps") pursuant to ISDA Master Agreements. Pursuant to the Series 2008C Swaps, Wells Fargo Bank, National Association ("Wells Fargo") and PNC Bank, National Association ("PNC") pay AHCN the sum of a percentage of the one-month London Interbank

Offered Rate ("LIBOR") plus a spread, and AHCN pays Wells Fargo and PNC amounts based on a fixed rate (approximately 3.605%). All Wells Fargo, PNC and AHCN payments are made on a same day net payment basis with reference to a notional amount that declines over the term of the Series 2008C Swaps. Unless terminated earlier in accordance with their terms, the Series 2008C Swaps' scheduled termination date is November 1, 2038. Under certain circumstances, however, the Series 2008C Swaps are subject to termination prior to the scheduled termination date.

See Note F – Fair Value Measurements and Note H – Derivatives to the Interim Condensed Consolidated Financial Statements for the fair value and a description of the accounting treatment of Advocate's interest rate swap arrangements.

Securities Lending:

As part of the management of the investment portfolio, Advocate has entered into an arrangement whereby securities owned by Advocate are loaned, primarily to brokers and investment banks. The loans are arranged through a bank. Borrowers are required to post collateral in the form of cash or highly rated securities for securities borrowed equal to approximately 102% to 105% of the value of the security loaned on a daily basis. The bank is responsible for reviewing the credit-worthiness of the borrowers. Advocate has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At September 30, 2017, Advocate loaned approximately $17.1 million in securities and accepted collateral for these loans in the amount of $17.3 million, of which $17.3 million represented cash collateral. The collateral received under the securities lending program has been reflected as a current asset and a current obligation payable in the interim condensed consolidated balance sheets presented. The balance of securities loaned and accepted collateral fluctuates daily.

Potential for New Corporate Affiliations

Health care is currently a very dynamic market. Advocate is actively exploring new opportunities for affiliations with, and acquisitions of, other institutions and organizations. Advocate will continue to consider any potential affiliations that may be in the best interest of Advocate.

To better align Advocate's and APP resources related to capitated and other risk arrangements the APP bylaws were amended. The amendment resulted in Advocate obtaining a majority of board seats and certain reserve powers. Accordingly, APP's financial statements are consolidated in Advocate's financial statements as of January 1, 2017. See Note L - Affiliation and Merger of the Interim Condensed Financial Statements for the third quarter ended September 30, 2017 for additional information on this matter.

There were no other significant affiliations, acquisitions or divestitures completed during the nine months ended September 30, 2017 or from October 1, 2017 through the date of this document.

Commitments

Advocate has various commitments to construct additions and renovations to its medical facilities, and implement and procure information technology projects and services, and future minimum rental commitments under the terms of non-cancellable leases. Obligations entered into prior to January 1, 2017 are described in Note 11 to the Advocate Health Care Network and Subsidiaries 2016 Audited Consolidated Financial Statements.

Executive Management

In January 2017, Bruce Smith, Senior Vice President and Chief Information Officer announced his retirement effective June 30, 2017. Effective July 24, 2017, Barbara Byrne, M.D. was appointed as the new Senior Vice President and Chief Information Officer. Prior to joining Advocate, Dr. Byrne most recently worked at Edward-Elmhurst Healthcare, serving as vice president and chief information officer since 2009 before being named executive vice president – system chief medical and quality officer, earlier this year. There were no other changes to executive management from January 1, 2017 through the date of this document.

Ratings

Moody's Investors Services, Inc. ("Moody's"), Standard and Poor's Rating Services ("S&P") and Fitch Ratings ("Fitch") have assigned long-term ratings of Aa2, AA+ and AA, respectively, to the long-term debt of Advocate. S&P raised the long-term rating to "AA+" from "AA" on February 3, 2017. There were no other changes to Advocate's assigned long-term ratings during 2016 or from January 1, 2017 through the date of this document.

In connection with various bond issues Advocate has obtained short-term credit ratings from each of the three rating agencies. Moody's, S&P and Fitch have assigned short-term ratings of Aa2/VMIG1, A-1+ and F1+, respectively. With the May and July 2016 remarketing of the Series 2003C and 2003A bonds to their respective maturity dates in November 2022, these bonds now only carry a long-term rating. There were no changes to Advocate's assigned short-term ratings during 2016 or from January 1, 2017 through the date of this document.

The aforementioned ratings reflect only the view of the rating agency providing the same and an explanation of the significance of such ratings may be obtained only from the rating agency furnishing the same. Certain information and materials not included in this unaudited quarterly report may have been furnished to the rating agencies. Generally, rating agencies base their ratings on the information and materials so furnished and on investigations, studies and assumptions performed or made by the rating agencies. There is no assurance that the ratings will continue for any given period of time or that these ratings will not be revised downward or withdrawn entirely by any of such rating agencies if, in the judgment of such rating agency, circumstances so warrant. Any downward revision or withdrawal of such ratings may have a material adverse effect on the market price of Advocate's outstanding tax-exempt bonds.

Proposed Federal Tax Reform Legislation

On November 2, the House Ways and Means Committee released a bill titled "Tax Cuts and Jobs Act" (the "House Bill"), and on November 9, the U.S. Senate released the Joint Committee on Taxation, Description of the Chairman's Mark of the "Tax Cuts and Jobs Act," which summarizes the Senate's version of a "Tax Cuts and Jobs Act" bill (the "Senate Bill"). Both the House Bill and Senate Bill propose sweeping changes to federal taxation of corporations and individuals. The House Bill also eliminates the ability of governmental entities to issue "private activity bonds" for the benefit of nongovernmental persons, which would include the bonds that are issued by governmental entities for the benefit of Advocate. The Senate Bill contains no similar limitation. Both the Senate Bill and the House Bill include provisions eliminating the ability to issue "advance refunding bonds," which are any bonds issued to refinance existing debt more than 90 days in advance of the redemption

date or maturity date of such existing date. Management cannot predict with any certainty whether any federal tax reform legislation will have any material adverse effect on the financial condition or operations of Advocate.

Debt Limit Increase

The federal government has through legislation created a debt "ceiling" or limit on the amount of debt that may be issued by the United States Treasury. In the past several years, political disputes have arisen within the federal government in connection with discussions concerning the authorization for an increase in the federal debt ceiling. Any failure by Congress to increase the federal debt limit may impact the federal government's ability to incur additional debt, pay its existing debt instruments and to satisfy its obligations relating to the Medicare and Medicaid programs. On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015 (the "2015 Budget Act"), increasing the budget caps imposed by the Budget Control Act of 2011 for fiscal years 2016 and 2017, authorizing $80 billion in increased discretionary spending over the next two years and suspending the debt limit until March 15, 2017. The Consolidated Appropriations Act for FY 2017, signed into law on May 5, 2017 by President Trump, funds the federal government for the remainder of the current federal fiscal year. Management is unable to determine at this time what impact any failure to increase the federal debt limit may have on the operations and financial condition of Advocate, although such impact may be material. Additionally, the market price or marketability of Advocate's outstanding bonds in the secondary market may be materially adversely impacted by any failure to increase the federal debt limit.

Industry Risks

For a description of Industry risks, see "BONDHOLDERS' RISKS" in the forepart of the Official Statement dated October 14, 2015 ("Bondholders' Risks") relating to the $71,645,000 Illinois Finance Authority Revenue Bonds, Series 2015B (Advocate Health Care Network), which is available on EMMA. The following is supplemental information updating some of the risks described therein:

The Bondholders' Risks describes the ACA, which was enacted in 2010 to overhaul the United States health care system and regulate many aspects of health care delivery. As described therein, attempts to amend and repeal provisions of the ACA were introduced in previous Congressional sessions, and President Trump and Congressional leadership have started the process to repeal and replace the ACA with the American Health Care Act. After an unsuccessful attempt to pass the bill in March 2017, the House of Representatives passed an amended version on May 4, 2017. Subsequent Senate debates and amendments to the American Health Care Act evolved into a vote on the Healthcare Freedom Act of 2017, also known as the "skinny repeal" bill, which proposed, most notably, to eliminate the penalties for individuals not obtaining health insurance coverage or large employers not offering health insurance coverage. The Congressional Budget Office projected that the repeal bill would increase the number of uninsured people by 15 million and cause premiums to rise approximately 20% for buyers in the individual market. The final Senate vote fell short on July 28, 2017, and while Congress appears to have redirected its focus to other items on leadership's agenda, efforts to repeal elements of the ACA such as individual mandate have been part of the debate in other legislation—most recently, the Tax Cut and Jobs Act being debated during the fall of 2017. However, it is not possible to predict with any certainty whether and when efforts to repeal or replace the ACA, in whole or in part, will be successful. Such efforts would likely focus on items similar to those addressed by the American Health Care Act, including reforming individual and employer mandates, exchanges, insurance industry regulation, Medicaid expansion, and the taxes necessary to pay for these reforms.

In December 2016, the 21st Century Cures Act (the "Cures Act") was enacted. The Cures Act creates broadened patient access to care, involving patients in new research, and leveraging technology to create efficiencies. The Cures Act will support efforts to improve telehealth services in Medicare and will improve the process for determining which Medicare treatments are covered, leading to increased access to treatments for Medicare beneficiaries. It will also allow Medicare beneficiaries to shop for services to find the most cost-effective treatments available. In addition, the Cures Act contains provisions that affect reimbursement for hospital outpatient departments, as discussed in more detail below.

Effective October 1, 2013, CMS adopted a policy known as the Inpatient Hospital Prepayment Review "Probe & Educate" review process (the "Two-Midnight" rule). The Two-Midnight rule specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. CMS adopted the policy due to growing concern with the overuse of the "observation" status at hospitals after it found that Medicare beneficiaries were spending extended periods of time in observation units without being admitted as inpatients. After several legislative and administrative delays to implementation, as well as lawsuits from industry stakeholders, on October 30, 2015, CMS finalized updates to the "Two-Midnight" rule, which were also included in the calendar year 2016 Medicare Outpatient Prospective Payment System ("OPPS") final rule. In contrast to the proposed rules, the final rule created exceptions that allow some stays not expected to extend past two midnights to qualify for inpatient reimbursement under Part A. The final rule also shifted review of hospitals' Two-Midnight rule compliance from Medicare Administrative Contractors and Recovery Audit Contractors to Quality Improvement Organizations, which are more collaborative and educational. The effect of the "Two Midnight" rule on Advocate's operations is still unclear.

The American Hospital Association and several hospitals filed lawsuits against HHS contending that the rule deprives hospitals of proper Medicare reimbursement for caring for patients. In its fiscal year 2017 Inpatient Prospective Payment System Final Rule published on August 2, 2016, CMS reversed the Two-Midnight Rule's 0.2% reduction in hospital payments that were in place 2014 - 2016, and implemented a temporary 0.2% increase in fiscal year 2017 as well as a one-time increase of 0.6% in fiscal year 2017 payments to offset cuts made in the three preceding fiscal years.

Section 603 of the 2015 Budget Act reduces Medicare payments to newly enrolled provider-based, off-campus hospital outpatient departments ("HOPDs") by excluding such facilities from payment under the OPPS beginning January 1, 2017. While this change does not affect already existing and enrolled provider-based, off-campus HOPDs that were billing for services prior to November 2, 2015, newly enrolled provider-based, off-campus HOPDs will receive lower payments than in previous years for providing the same services.

In November, 2016, CMS released its calendar year 2017 OPPS final rule. Initially, CMS had proposed a requirement that off-campus HOPDs offer the same services as they did on November 2, 2015 to be excluded from the site-neutral payment provisions, but CMS did not finalize this proposal, electing instead to monitor expansion of clinical services lines in these HOPDs to consider whether a potential limitation on service line expansion should be adopted in the future. The rule does, however, implement a prohibition on the relocation or changes in ownership for grandfathered HOPDs. As part of implementing the transition to the Physician Fee Schedule ("PFS") as the payment methodology for HOPDs no longer eligible under OPPS, the MPFS final rule for calendar year 2018 reduces payment for services in ineligible HOPDs by 20 percent (from 50 percent of the OPPS payment rate to 40 percent).

The Cures Act expands the categories of projects that would be exempt from the decrease in OPPS reimbursement payments. They include: (i) off-campus outpatient department if the host hospital had submitted a voluntary provider-based attestation to CMS before December 2, 2015, as long as the construction of the new off-campus outpatient department is complete and the hospital is accepting or poised to accept patients; (ii) off-campus outpatient department locations providing services on or after January 1, 2018, that had a "binding written agreement with an outside unrelated party for the actual construction" of the new off-campus outpatient department before November 2, 2015, as long as the host hospital make certain attestations and certifications within 60 days of the enactment of the Cures Act; and (iii) off-campus outpatient departments of certain cancer hospitals that file provider-based attestations within 60 days of the date of enactment of the Cures Act (for departments meeting provider-based requirements between November 2, 2015, and the date of enactment) or within 60 days of the date of meeting provider-based requirements.

In February 2016, CMS issued the Medicare overpayments final rule, with an emphasis for providers on developing robust compliance programs. In the final rule, CMS imposes a new "reasonable diligence" standard for identifying overpayments that must be reported and returned within 60 days. CMS clarifies that the 60-day timeframe for report and return begins when either reasonable diligence is completed (including determination of the overpayment amount) or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment. CMS relaxed the look back period for identifying overpayments in its final rule from 10 years to 6 years. The final rule does, however, impose an affirmative duty to proactively determine whether overpayments have been made. The effect of these changes on existing programs and systems of Advocate cannot be predicted.

In September 2016, CMS issued a final rule that revises the benchmark rebasing calculations for accountable care organizations ("ACOs"). While these revised benchmark rebasing calculations may be particularly attractive for high performing ACOs, the delayed onset of these revised benchmark calculations (e.g., the revised methodology would not apply for the earliest ACOs until the start of their third participation agreement in 2019) leaves the MSSP ACO landscape somewhat uncertain.

As described in Bondholders' Risks, in April 2015, the Medicare Access and Children's Health Insurance Program Reauthorization Act ("MACRA") was enacted. MACRA reauthorized the Children's Health Insurance Program ("CHIP") at the time; however, the reauthorization expired on September 30, 2017. Congress continues to struggle with passing legislation to extend CHIP because of partisan disagreement over how to pay for the bill. Although the House passed reauthorization legislation, the Championing Healthy Kids Act, it has encountered opposition in the Senate because of payment disagreements. While most states have enough funding to carry CHIP through the end of 2017, some advocates have expressed concern children in some states, including those in Illinois, face the possibility of losing coverage if CHIP is not reauthorized soon.

In addition to reauthorizing the children's health insurance program ("CHIP"), MACRA also required CMS to implement drastic changes to the physician payment methodology under Medicare. Historically, Medicare payments for physician services had been linked to the Sustainable Growth Rate ("SGR"). The SGR acted as a limit to the growth of Medicare payments for physician services, and was linked to changes in the U.S. Gross Domestic Product over a ten-year period. The use of the SGR in determining physician fee schedule updates was widely criticized, and was consistently neutralized with Congressional intervention which served to delay considerable decreases to Medicare physician payments. MACRA replaces the SGR formula with statutorily prescribed physician payment updates and provisions. MACRA also included details to pay for the approximately

$210 billion cost associated with eliminating the SGR formula. On November 4, 2016, CMS published a final rule effective January 1, 2017, implementing MACRA, setting forth CMS' implementing regulations to replace the SGR formula with a new system that links the SGR with a new system that links Medicare fee-for-service ("FFS") payments for physicians and other practitioners to care delivery, quality and value-based variables.

MACRA establishes a "Quality Payment Program" ("QPP"). The QPP requires clinicians to participate in the evolving "value-based" payment and delivery system in a way that is intended to impact the delivery of FFS Medicare. The rule applies to Medicare Part B payments for professional services furnished by the majority of all physicians and other individual practitioners furnishing services under Medicare. From a policy perspective, MACRA and the QPP seek to require rapid migration from straight FFS to a largely "pay for value" payment system, consistent with CMS' stated goal of linking 90% of Medicare FFS payments tied to quality or value by the end of 2018.

The first QPP pathway involves a migration to alternative payment models ("APMs"), where clinicians may choose to participate in initiatives directed at changing how care is delivered, such as the MSSP, and reward those groups of participating providers who take the initiative (and bear the financial and other risk) to try to succeed in such programs. The second "fallback" QPP participation vehicle is the establishment of a merit based payment incentive system, ("MIPS"), as a means to link the FFS payments made to the vast majority of physicians and other individual practitioners to measures directed at improving quality, innovation and value. Under MIPS, clinicians or groups will be measured and assessed upward or downward payment adjustments based upon their achievements in quality, resource use, improvement activities and advancing care information. CMS finalized its June 30, 2017 proposed rule on November 2, 2017 to modify previous provisions of the QPP rule. These modifications include adjustments to participation criteria to reduce the burden on small practices by exempting lower volume practices, awarding additional points for their participation and granting them flexibility to participate with other practices. The final rule also adjusted the weights attributed to the payment metrics by increasing the cost weight and reducing the quality weight. System management is reviewing MACRA and its implementing rules as proposed to be modified; however, Management cannot predict whether MACRA will have a material impact on the results of operations and financial condition of the System.

340B Drug Pricing

Hospitals that participate in the prescription drug discount program established under 340B of the Federal Public Health Service Act (the "340B Program") are able to purchase certain prescription drugs for their patients at a reduced cost. After proposing omnibus guidance for the 340B Program in 2015, the federal Health Resources and Services Administration ("HRSA") withdrew its proposal in 2017, and it remains to be seen whether certain elements of the 340B Omnibus Guidance will be released via other sub regulatory mechanisms, including HRSA Office of Pharmacy Affairs ("OPA") or Apexus FAQs, or even HRSA OPA audit findings. Most recently, in its calendar year 2018 OPPS final rule effective January 1, CMS implemented significant Medicare Part B payment reductions for separately payable, non-pass-through drugs purchased through the 340B program that are provided in hospital outpatient settings. The rule reduces payment from the previous rate of average sales price (ASP) plus 6 percent to ASP minus 22.5 percent. Drugs not purchased through the 340B program will continue to be paid for at the ASP plus 6 percent rate. Certain providers are exempted from the reduced payment policy for CY 2018, including children's hospitals and PPS-exempt cancer hospitals. CMS is implementing this policy in a budget neutral manner by offsetting the projected decrease in drug payments of $1.6 billion by redistributing an equal amount for non-drug items and services across the OPPS.

Continued Pressures on and Changes to State Funded Programs

In Illinois, Medicaid is administered by the Illinois Department of Healthcare and Family Services ("IDHFS"). The State of Illinois fiscal condition is challenged which can affect its budget for social programs such as Medicaid. Historically, federal payments and amounts appropriated by the Illinois General Assembly for payment of Medicaid claims have not been sufficient to reimburse hospitals for their actual costs of providing services to Medicaid patients. Also, the State of Illinois has routinely failed to pay Medicaid claims on a timely basis. The State of Illinois endured an ongoing budget impasse, operating with no budget or six-month stop-gap budgets from July 1, 2015 through June 30, 2017. Recently, on June 30, 2017, a federal judge ordered Illinois to begin paying $293 million every month in state money toward its backlogged Medicaid obligations and additional $1 billion over the course of the next year. Finally, the Illinois legislature enacted a budget on July 6, 2017 retroactive to July 1, overriding a veto by Governor Rauner. Management is unable to predict if the newly enacted budget will result in timely payment of the court-ordered Medicaid obligations to health care providers or how future state budgets and legislation will impact payment rates, program services or other changes to the Medicaid program.

See the results of operations section for information regarding the Medicaid Assessment and ACA related programs.

Additionally, the failure by the State of Illinois to pay Medicaid claims on a timely basis may have an adverse effect on Advocate's operating results, cash flow and financial condition.

Laws, Regulations and Related Litigation

As a health care provider, Advocate and its subsidiaries and affiliates are subject to extensive and frequently changing federal, state and local laws and regulations governing various aspects of our business. In particular, Advocate and its subsidiaries provide a broad range of services, many of which are regulated by different government agencies, subject to differing regulatory schemes and subject to contractual reviews and program audits in the normal course of business. Many operations that Advocate and its subsidiaries undertake are subject to significant governmental certification and licensing regulations, as well as federal and state laws, including those relating to:

- fraud and abuse;
- billing and pricing practices;
- kickbacks, referrals, rebates and fee-splitting;
- antitrust;
- tax-exempt status, including intermediate sanctions;
- tax-exempt financing including the use of bond proceeds;
- marketing, sales, and pricing practices;
- privacy and security of personal health care information;
- human subject research;
- the handling and disposal of medical specimens, hazardous waste and controlled substances; and
- occupational safety and consumer protection.

Government agencies and private whistleblowers have made enforcement of the provisions relating to false claims, kickbacks, physician self-referral and various other fraud and abuse laws a major priority in recent years. Potential sanctions for violation of these statutes and regulations include significant fines and criminal penalties and the loss of various licenses, certificates and authorizations and loss of tax-exempt status.

On March 17, 2014, Advocate, certain of its subsidiaries, and certain of its board members and employees were named as defendants in a lawsuit challenging the "church plan" status of one of Advocate's defined benefit plans. See Note K, Legal. Regulatory and other Contingencies, of the Interim Condensed Financial Statements for the third quarter ended September 30, 2017 for additional information on this matter.

Advocate expects that the level of review and audit to which it and other health care providers are subject will increase. To foster compliance with applicable laws, Advocate has a compliance program that is designed to detect and correct potential violations of laws and regulations related to its programs. Advocate also tracks enforcement trends, closely reviews government advisories concerning suspect practices, and regularly undertakes to educate its officers, associates and vendors concerning applicable laws and regulations. However, many of the laws and regulations affecting Advocate and its subsidiaries and affiliates have not been interpreted by regulators or the courts or have been subject to varying interpretations. As a result, regulators may contend that they have broad authority to assert claims for noncompliance and assert claims or penalties based upon their interpretation of those requirements. It is not possible to determine the impact, if any, such claims or penalties would have upon Advocate and its subsidiaries.

As described in Bondholders Risks, violations under the 2009 Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and their implementing regulations are subject to HIPAA civil and criminal penalties, including monetary penalties and/or imprisonment. Advocate believes that all of its health care facilities are in substantial compliance with HIPAA, the HITECH Act, and the rules promulgated thereunder.

Billing Practices for Uninsured and Under-Insured Patients

Both Federal and State authorities have investigated the health care industry's billing practices for uninsured and underinsured patients. Billing and collection practices and procedures are governed by a detailed and complex array of federal Medicare statutes, regulations and policy pronouncements. Billing and collection practices of hospitals continue to be subject to the intense scrutiny of federal, state and local governmental agencies. Advocate management believes that its billing and collection practices comply with current law, policies and regulations though as indicated in the section above entitled "Laws, Regulations and Related Litigation", laws and regulations related to billing practices have not been interpreted by the courts or regulators or have been subject to varying interpretations. If challenged Advocate intends to vigorously defend its billing and collection practices.

As a faith-based health care organization, the mission, values and philosophy of Advocate form the foundation for its strategic plan. Advocate's mission is to serve the health care needs of individuals, families and communities through a holistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. The number of uninsured and underinsured individuals is a national issue and the State of Illinois has a significant number of uninsured and underinsured individuals. Families with income levels of up to six hundred percent of the federal poverty level are eligible for free or discounted care. Additionally, Advocate does not place liens on primary residences and considers employment status and financial resources

of insured and uninsured patients before taking legal action in its accounts receivable collection efforts. As community needs evolve Advocate periodically reviews and revises its policies and procedures relating to charity care. In response to the new 501 (r) requirements of the Code, which became effective for Advocate on January 1, 2016, Management reviewed its policies and procedures and believes Advocate is compliant.

Tax-Exempt Status

Certain Advocate entities are Illinois not for profit corporations, exempt from federal income taxation as organizations described in the Code. As not for profit tax-exempt organizations, these entities are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organizations and operations, including their operation for charitable purposes. At the same time Advocate, as a whole, conducts large scale complex business transactions and is a major employer in the geographic service areas in which it operates. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex healthcare organization.

Due to budget deficits and declining tax revenues and the growing numbers of uninsured and underinsured individuals in the United States, federal, state and local governments are increasingly scrutinizing the tax status of not-for-profit hospitals. Over the past several years, an increasing number of the operations or practices of healthcare providers have been challenged or questioned in an effort to determine whether they are consistent with the regulatory requirements for not for profit tax-exempt organizations. These challenges are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and in many cases are instead examinations of core business practices of the healthcare organizations. Areas that have come under examination have included, but have not been limited to pricing practices, billing and collection practices, the volume and definition of charitable care, community benefit standards, executive compensation, and exemption of property from state real property and state sales taxation. These challenges and questions have come from a variety of sources, including state attorneys general, the IRS, local and state tax authorities, labor unions, Congress, state legislatures and patients, and in a variety of forums, including hearings, audits and litigation.

The status of real property and sales tax exemptions for nonprofit health care providers has been under scrutiny in the State of Illinois for several years. As a result, in September 2012, the State of Illinois enacted legislation (the “Illinois Property and Sales Tax Act”) creating new standards for real property and sales tax exemptions for health care providers operating in the State.

The Illinois Property and Sales Tax Act provides that a hospital owner or hospital affiliate satisfies the conditions for an exemption from real property taxation if the value of “qualified services or activities” for the hospital year equals or exceeds the relevant hospital entity's estimated property tax liability for the calendar year in which exemption or renewal of exemption is sought. Nonprofit hospitals that satisfy this test will also be exempt from the State’s sales and use tax. The Illinois Property and Sales Tax Act includes a list of the items that are included within the definition of “qualified services and activities,” including charity care (free or discounted services pursuant to the hospital’s financial assistance policy, measured at cost); health services to low-income or underserved individuals (including, without limitation, financial or in-kind support relating to the care and treatment of low-income or underserved individuals); subsidies provided to State or local governments for programs related to health care for low-income or underserved individuals; support for State health care programs for low-income individuals; and the portion of unreimbursed costs attributed to providing, paying for, or subsidizing goods, activities or services that relieve the burden of government relating to health care for low-

income individuals, including, without limitation, the provision of medical education and training of health care professionals as well as the provision of emergency, trauma, burn, neonatal, psychiatric, rehabilitation or other special services.

Prior to the passage of the Illinois Property and Sales Tax Act, Illinois law required organizations exempt from sales and use tax to request renewal of their exemption every five years. Certain Advocate entities applied for renewal of their exemptions, and subsequently received letters from IDOR indicating that their applications were under review. In these letters, the Illinois Department of Revenue ("IDOR") indicated that these entities could continue to operate under their current exemptions (provisional extensions) until a final determination is made.

As requested by the State, each Advocate not-for-profit legal entity filed form STAX 300-HR to extend the expiration date of its sales tax exemptions past their former expiration date of July 31, 2016. Advocate has received new exemption letters which are valid for five years. The State subsequently developed a new annual certification form, the STAX-300-HC. Advocate has filed these forms on a timely basis.

In September 2015, a circuit court judge entered summary judgment in favor of IDOR in a lawsuit challenging the constitutionality of the Illinois Property and Sales Tax Act finding the Illinois Property and Sales Tax Act to be constitutional. On January 5, 2016, the Illinois Fourth District Appellate Court (the "Appellate Court") ruled that Section 15-86 of the State of Illinois Property Tax Code is unconstitutional. The court found that the law did not meet both exemption tests contained in the State of Illinois' constitution. The ruling was not a determination on whether, or not, hospitals are eligible for property tax exemption. This ruling was appealed to the Illinois Supreme Court. The Illinois Attorney General's Office filed a motion to stay the enforcement of the Appellate Court ruling. In March 2017, the Illinois Supreme Court overturned the Appellate Court's decision on jurisdictional grounds without reaching a decision on whether Section 15-86 of the Illinois Property Tax Code is constitutional, remanding the case to the circuit court for reconsideration. On September 27, 2017, the Illinois Supreme Court agreed to hear this case and its challenge to the constitutionality of the law. A ruling is not expected until late 2018. As indicated above, the matter of the constitutionality of this law is still unresolved. In addition, in May 2016, a lawsuit was filed with the Circuit Court of Cook County, Illinois (*Thornmeadow Partners v. NorthShore University Health System*) pursuant to which the plaintiff, purporting to represent Illinois taxpayers, seeks monetary damages from all Illinois hospitals that obtained exemptions under Section 15-86, since the Appellate Court ruled that the law was unconstitutional.

Management cannot predict whether the litigation regarding the Illinois Property and Sales Tax Act will have a material impact on the operating results, cash flow and financial condition of Advocate in regards to future property or sales tax exemption applications if an adverse ruling is received.

As set forth elsewhere in this report, a variety of Advocate's practices are under examination by a number of governmental agencies and private parties. No government entity has challenged Advocate's tax-exempt status to date.

Charity Care and Patient Billing Legislation

In addition to the increased scrutiny that tax-exempt hospitals have faced in the past few years through federal and state charity care litigation, congressional hearings and IRS examinations, the Office of the Illinois Attorney General (the "Attorney General") has also directed its attention toward state legislative and regulatory

initiatives relating to tax-exempt hospitals. Under current Illinois law, tax-exempt hospitals are required annually to submit audited financial statements and detailed community benefits reports to the Attorney General.

Corporate Compliance

Advocate has established a Business Conduct Program (the "Compliance Program") intended to assist Advocate Board members, associates, physicians and vendors to conform their actions to comply with the numerous laws and regulations applicable to the healthcare industry. As part of this program, Advocate has developed and implemented Business Conduct Guidelines, a Conflict of Interest Policy and a Code of Business Conduct to describe such laws and regulations and to give clear guidance as to the manner in which Advocate associates are to conduct their day to day activities. The Compliance Program is overseen by the Vice President, Chief Compliance Officer, who reports functionally and administratively to Advocate's Senior Vice President and General Counsel as well as functionally to the President and Chief Executive Officer, and Advocate Business Conduct Committee. The Compliance Program is primarily concerned with the following areas: conflicts of interest, Medicare/Medicaid fraud and abuse laws, Stark anti-referral legislation, Medicare and Medicaid coding and billing procedures and patient privacy (HIPAA and related laws). In addition, a Business Conduct Hotline provides associates with an anonymous means to report violations of the program or seek guidance and clarification on issues or concerns they might have with respect to their own conduct or the conduct of other Advocate associates. Advocate has educated its Board, employees, physicians and vendors as to the elements of the Compliance Program. The Compliance Program undergoes periodic review and updates based on new developments.

Dates of the Condensed Consolidated Financial Statements and Management Discussion and Analysis of Financial Condition and Results of Operations

The interim condensed consolidated financial statements and the sources of system net patient service revenue, utilization statistics and ratios (Attachment 1) and liquidity worksheet (Attachment 2) were prepared as of October 16, 2017. The management discussion and analysis of financial condition and results of operations were prepared as of November 14, 2017.

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Attachment 1

Sources of System Net Patient Service Revenue, Utilization Statistics and Ratios

	For the quarter ended September 30,		For the nine months ended September 30,		For the year ended December 31,
	2017	2016	2017	2016	2016
SOURCES OF SYSTEM NET PATIENT SERVICE REVENUE					
Medicare and Medicare Managed Care	29%	28%	29%	29%	29%
Medicaid and Medicaid Managed Care	16	15	16	14	14
Managed Care	46	47	47	50	50
Self pay, workers' compensation and other	9	10	8	7	7
	100%	100%	100%	100%	100%
UTILIZATION STATISTICS					
Acute Care Hospitals:					
Admissions	42,703	42,098	127,658	127,493	169,786
Observation Cases	13,536	14,970	42,291	43,894	58,624
Total Admissions and Observation Cases	56,239	57,068	169,949	171,387	228,410
Average Length of Stay (days)	4.66	4.69	4.71	4.68	4.70
Outpatient Visits	478,263	482,736	1,449,597	1,456,464	1,937,266
Covered Lives (a)					
Commercial	296,842	284,002	296,842	284,002	288,381
Medicare Advantage	46,691	45,152	46,691	45,152	46,755
Physician Practice Visits	927,156	919,448	2,822,749	2,719,827	3,654,063
Home Health Care Admissions	6,736	6,699	20,104	20,249	26,563
FINANCIAL RATIOS					
Operating Margin	3.6%	3.6%	3.3%	4.1%	4.7%
Net Margin	10.5%	15.0%	11.6%	9.8%	10.1%
Operating Cash Flow Margin	9.3%	9.8%	9.0%	10.1%	10.5%
EBITDA Margin	16.3%	21.8%	17.8%	15.8%	15.7%
OTHER FINANCIAL INDICATORS					
Days Cash on Hand (b)			353	371	370
Debt Service Coverage (c)			9.1x	8.7x	8.5x
Debt to Capitalization Ratio			20.2%	22.3%	21.8%
Cash to Debt			321.4%	298.4%	297.0%

(a) September 30 and December 31, 2016 includes risk based covered lives contracted through Advocate Physician Partners which was a non-consolidated affiliate in 2016.

(b) The days cash on hand calculation includes assets limited to use and investments under securities lending program, and excludes the Medicaid assessment payable/expense for all periods presented as such amounts are not payable until the additional Medicaid revenue is received.

(c) Calculated as required by the terms of the Master Trust Indenture (Amended and Restated).

The Sources of Net Patient Service Revenue, Utilization Statistics and Ratios was prepared on October 16, 2017

Attachment 2

Advocate Health Care Network and Subsidiaries
Liquidity Summary as of September 30, 2017
(dollars in thousands)

ASSETS (Gross)		
Daily Liquidity		
Money Market Funds (Moody's rated Aaa)	$88,068	
Dedicated bank lines (of credit)	0	
Operating Cash	439,592	
Overnight Repurchase Agreements (Collateralized by Treasuries; P-1 Counterparty)	0	
US Treasuries & Aaa-rated Agencies (<3 year maturity)	22,415	
US Treasuries & Aaa-rated Agencies (>3 year maturity)	107,412	
Subtotal Daily Liquidity (Cash & Securities)		**$657,486**
General Purpose Line of Credit		325,000
Subtotal Daily Liquidity		982,486
Weekly Liquidity		
Publicly Traded Fixed Income Securities (Aa3 or higher) and P-1 Commercial Paper	668,811	
Other Investment Grade Publicly Traded Fixed Income Holdings	0	
Exchange Traded Equities (Stock and Mutual Funds)	934,816	
Subtotal Weekly Liquidity		1,603,627
TOTAL DAILY AND WEEKLY LIQUIDITY		**$2,586,113**
Monthly Liquidity		
Funds, vehicles, investments that allow withdrawals with one month notice or less		589,576
Longer-Term Liquidity		
Funds, vehicles, investments that allow withdrawals with greater than one month notice (Hedge & Private Equity)		2,478,077
LIABILITIES (Self-Liquidity Debt Shorter than 13 Months & CP)		
Scheduled Mandatory Tender VRDBs Within 13 months		
Mandatory tenders scheduled on: 07/30/2018	21,975	
Subtotal Other Liabilities		21,975
TOTAL LIABILITIES (Self-Liquidity Debt & CP Shorter Than 13 months)		**$21,975**

The Liquidity Summary was prepared on October 16, 2017