Aurora Health Care®

Aurora Health Care, Inc. and Affiliates

Unaudited Consolidated Financial Statements and Other Information
For the Year Ended December 31, 2016

This document is dated May 19, 2017

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INTRODUCTION

This Annual Report contains information concerning Aurora Health Care, Inc., a Wisconsin nonstock, not-for-profit corporation (the “Corporation”) and its affiliates (collectively, "Aurora"). Under the terms of the Second Restated Master Trust Indenture, dated January 1, 2012 (the “Master Indenture”), the Corporation and certain of its affiliates (collectively, the “Obligated Group”) have agreed to be jointly and severally obligated for revenue bonds (the "Master Notes"). The Master Indenture requires Aurora to disclose certain financial and operating data within a pre-determined period subsequent to year-end, December 31, 2016.

The Corporation is the parent corporation of a group of nonprofit and for profit corporations and other organizations that own and operate health care facilities, provide health care-related services throughout eastern Wisconsin, northern Illinois, and the upper peninsula of Michigan and provide internal support services to Aurora. The Corporation and certain of its affiliates are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the "Code") and have been recognized as tax exempt on related income pursuant to Section 501(a) of the Code. The Corporation provides leadership and management functions for its affiliates and subsidiaries and has no material revenue producing assets of its own, other than investments in certain joint ventures.

In addition to providing the services described above, Aurora has entered into strategic joint ventures and other arrangements with third parties to provide greater access to high quality, cost efficient care in the communities we serve. Most notably, Aurora entered into a joint venture with Anthem Blue Cross Blue Shield in 2016 to form a jointly owned health insurance company, Wisconsin Collaborative Insurance Company, an HMO which will offer a narrow network insurance product to employers. In addition, Aurora is a member in AboutHealth LLC ("AboutHealth"), a network of six health care organizations in Wisconsin which was developed to build upon and advance the clinical quality, efficiency, and customer experience attributes that are shared among the organizations.

References to Aurora in this document are to the Corporation and all of the affiliates and subsidiaries consolidated with it pursuant to accounting principles generally accepted in the United States of America (“GAAP”). References to the Corporation are references only to the parent corporation, and should not be read to include any of the Corporation’s affiliates and subsidiaries.

AURORA

Aurora is one of the largest provider of inpatient and outpatient health care in the State of Wisconsin. It provides integrated health care services at approximately 250 geographic sites in eastern Wisconsin, northern Illinois, and the upper peninsula of Michigan, including primary and specialty care, pharmacies, behavioral health care, emergency care, rehabilitation, home care, and end-of-life care. Its operations include 14 acute-care hospitals and one psychiatric hospital (collectively, the "Aurora Hospital Facilities"), 157 physician clinic facilities (collectively, the "Aurora Clinic Facilities"), one of the largest home health care organizations in Wisconsin, 75 retail pharmacies, and other health care and related services.

For the year ended December 31, 2016, Aurora provided services to approximately 1.2 million patients in approximately 7.4 million patient encounters. During that same period, it reported adult inpatient days of approximately 446,000; admissions of approximately 103,000; and physician clinic, hospital outpatient and other visits of 7.4 million. Aurora had $5.3 billion in assets as of December 31, 2016 and total operating revenue of approximately $5.1 billion for the year ended December 31, 2016. At December 31, 2016, Aurora employed approximately 1,730 physicians.

Aurora is nationally recognized for quality. Recent awards and recognitions include:

- Truven Health Analytics (March 2017): Top 100 Hospital among small community hospitals (Aurora Medical Center Manitowoc County and Aurora Medical Center Oshkosh).

- U.S. News & World Report, Best Regional Hospitals Ranking (August 2016): Nationally ranked in three specialties (Aurora St. Luke's Medical Center). High performing specialties in seven specialties (Aurora St. Luke's Medical Center). Recognized ranking for Northeastern Wisconsin (Aurora BayCare Medical Center and Aurora Medical Center Grafton).

- Milwaukee Business Journal: Central City Business Awards, Community Impact Award 2016.

SYSTEM STRENGTHS

Market Leadership: Aurora is a market leader in acute care admissions in several service areas, including Greater Milwaukee South and Waukesha, Sheboygan, Calumet and Greater Milwaukee North, and Burlington and Walworth, which enhances Aurora's ability to (1) attract payers and enter into long-term managed care contracts, (2) assume risk-based payments, and (3) recruit physicians and other medical personnel.

Integrated System: Aurora provides a full spectrum of care through its established network of physicians, acute care hospitals and complimentary outpatient services, psychiatric hospital, pharmacy and home health. The breadth of its network assists Aurora in managing costs and patient care, better positioning Aurora for value-based purchasing and population health management, and provides Aurora with a diverse revenue base. Aurora's strength as an integrated health system also provides for strong intrasystem referrals, with smaller community facilities transferring patients to the larger Aurora Hospital Facilities, such as Aurora St. Luke's Medical Center. The breadth of its network has also resulted in an

increased share of acute care admissions in many of its service areas; higher patient loyalty; improved quality metrics; more efficient care delivery; increased usage of acute care/physician/ancillary services; and accountable care and integrated system savings.

Information Technology: Aurora Hospitals and Clinics utilize a universal, shared, electronic health record, Epic, also referred to as SmartChart. Aurora's use of a single health record is driving cost efficiency, which has had a positive effect on operating income and is better positioning Aurora for value-based purchasing. This technology, together with Aurora's strength as an integrated health system, is expected to improve patient care and better position Aurora for population health management.

Quality and Cost: In a report published by *"HCTrends"* in January 2015 that correlates quality achievements and cost efficiency, Aurora was recognized as one of the lowest cost and highest quality providers in southeastern Wisconsin. Patients from all 50 states have been treated at Aurora St. Luke's Medical Center (Aurora's flagship hospital), evidencing Aurora's national recognition for quality of care. Aurora has exceeded management's expectations on the value-based purchasing provisions of the Affordable Care Act (earning full reimbursement at 12 out of Aurora's 14 acute-care hospitals).

Strategic Partnership: Aurora's strategic partnership with other health care organizations in Wisconsin, "AboutHealth", has continued in 2016. The partnership was developed to build upon and advance the clinical quality, efficiency and customer experience attributes that are shared among the six organizations. The other members of the partnership include Aspirus, Bellin Health, Gundersen Health System, ProHealth Care, and ThedaCare. The organizations in the partnership use the same technology for electronic medical records, making it easier for patients to access their records and share information with doctors in the network.

Aurora is also collaborating with Marquette University on building and staffing a state-of-the-art Athletic Performance Research Center. Under the proposed terms, Aurora will make a capital investment of up to $40.0 million and will become a one-third owner of the Athletic Center, which will be focused on athletic performance and research, innovation and select clinical services. The new facility would allow for further expansion of Aurora Sinai Medical Center's Sports Medicine Program to meet increasing demand. It will also help to attract and retain the nation's top physicians and physical therapists who seek the opportunity to work with high-level athletes. Most importantly, the findings and results that Aurora will be able to obtain through this collaboration will help develop and drive innovations around community health and population health initiatives.

In December 2016, Aurora announced an agreement with Walgreens to own, operate and provide all clinical services at eight retail health clinics located in Walgreens across eastern Wisconsin. Five existing clinics will transition in Spring 2017 and the remaining three locations will newly open in the Spring 2017.

Employed and Closely Aligned Physicians: Aurora has historically placed an emphasis on increasing the number of its employed physicians and currently employs approximately 1,730 physicians, more than half of its medical staff. Employed physicians are organized as a single, system-wide medical group. Aurora's

total medical staff of approximately 3,225 physicians, including its employed physician base and closely aligned physicians, allows for a stable revenue stream and a reliable and predictable referral base. Although Aurora continues to actively recruit physicians, its emphasis has shifted from increasing its physician component to improving physician utilization. Aurora's continued recruitment and solid rate of physician retention has resulted in a stable employed and closely aligned physician count. In 2016, revenue generated from employed and closely aligned physicians accounted for approximately 76% of Aurora's net patient service revenue.

The Aurora Network: Aurora developed The Aurora Network a network comprised of Aurora hospitals and clinics, physicians employed by Aurora and certain other independent physicians, with the goal of improving quality, outcomes, and the patient experience. The Aurora Network was first offered on January 1, 2013 when Aurora joined with two major health insurers, Anthem and Aetna, to market The Aurora Network to Wisconsin employers. Effective January 1, 2015 Aurora added another narrow network partner, Arise Health Plan and the network with Anthem was broadened to include additional health systems. Through 2016, Aurora contracted with five qualified health plans; Anthem Blue Cross and Blue Shield ("Anthem"), Common Ground Healthcare Cooperative ("Common Ground"), Molina Healthcare ("Molina"), United Healthcare ("United") and Arise Health Plan ("Arise") to market products that are offered on the health insurance exchange. As of December 31, 2016 there is no longer an ongoing relationship with Arise and United on the exchange.

Insurance Products: In April of 2016, Anthem and Aurora formed a new, joint venture health insurance company, Wisconsin Collaborative Insurance Company ("WCIC"), which will offer a commercial health insurance product called Well Priority. The unique joint venture partnership combines Aurora's care delivery system with Anthem's insurance expertise to create a new and better way of delivering health care to consumers. Well Priority, which utilizes a patient-centered approach to care, is designed to deliver lower overall cost of care, healthier consumers and higher patient satisfaction. Initially, WCIC will enroll only self-funded employer groups, with full-insured groups anticipated to join in January of 2018.

Well Priority products utilize Anthem's Blue Priority network. Health systems participating in the Blue Priority network include: Aspirus, Bay Area Medical Center, Bellin Health, Children's Hospital of Wisconsin, Fort HealthCare, Gundersen Health System, Meriter, ProHealth Care, Sauk Prairie Healthcare, ThedaCare, University of Wisconsin Hospitals, Clinics and American Family Children's Hospital, and Watertown Regional Medical Center.

BUSINESS STRATEGY

In a continuously changing health care environment, our purpose is unchanged, "We help people live well." To achieve this purpose our business strategies are designed to deliver high quality, cost effective care for our patients. We believe that integrated care is the best care for our patients and attracts best-in-class caregivers. Value is added through grouping physician, hospital, lab, pharmacy and other medical claims for each diagnosis to calculate the entire cost of treatment from the moment of diagnosis to the patient's return to health.

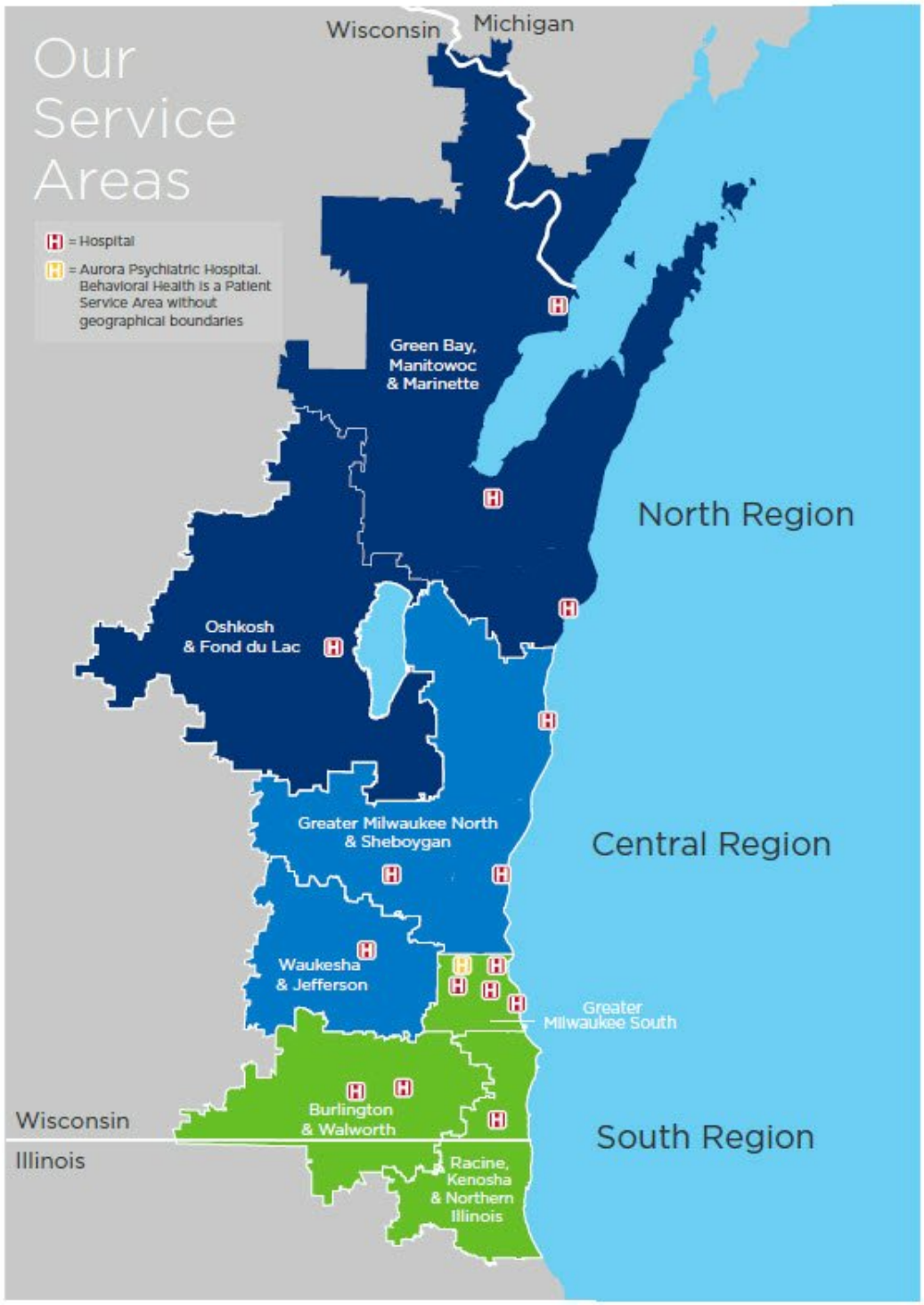
Quality of care is measured and reported monthly. Scorecards include service quality for services delivered in hospitals, emergency rooms, medical offices and home health visits and clinical quality for hospital, medical group, home health, lab and pharmacy, service lines and The Aurora Network. Leadership incentives are tied to achievement of clinical and service quality in addition to achievement of financial goals.

Our five year strategic plan, launched in 2016, was developed with three basic platforms:

Best People - Aurora aspires to be a destination employer for executives, physicians and other caregivers with exceptional leadership, a highly engaged workforce and embedding diversity and inclusion in all we do.

Best Brand - Aurora aspires to be a leading health care brand, nationally recognized for consumer centricity, quality and efficiency by knowing our consumers, concentrating on building brand strength and a differentiated consumer experience.

Best Value - Aurora aspires to be among the best values in health care, driven by medical excellence and integration, emphasizing innovation, clinical integration and operations optimization, transition to value-based care, financial health and leveraging informatics for competitive advantage.



Behavioral Health is an additional PSM which is not defined by geographical boundaries and therefore is not separately illustrated on the map above. Aurora has a 49% minority interest in a general acute care hospital located in Marinette, Wisconsin as illustrated on the map above. Bay Area Medical Center ("BAMC") is not included in Aurora's consolidated results of operations.

BUSINESS OF AURORA

The following discussion of the business of Aurora includes descriptions of facilities and other information, including acute care admissions and operating data that relates to facilities that are majority owned or controlled by Aurora.

Service Area

Aurora's service area covers approximately the eastern third of the State of Wisconsin (the "State"), a geographic area with a population of 3.5 million (or 60.3% of the State's population), as well as portions of two counties in northern Illinois that are contiguous to the Wisconsin border and the upper peninsula of Michigan.

Aurora's patient care operations are organized into eight patient service markets ("PSM's"), which are based on patient utilization patterns within a particular geographical area, other than the Behavioral Health PSM which is not defined by a geographical boundary. The PSM's are managed by region: North, Central, and South. The population of each PSM as of December 31, 2016 and the percentage of Aurora's total revenues generated by each PSM for the year ended December 31, 2016 are listed below.

PSM	Population[(1)]	Percentage of Total Revenue for Year ended December 31, 2016
North Region		
Green Bay, Manitowoc and Marinette	573,000	13%
Oshkosh and Fond du Lac	501,000	5%
Central Region		
Waukesha and Jefferson	312,000	5%
Greater Milwaukee North, Sheboygan and Calumet	954,000	20%
South Region		
Greater Milwaukee South	599,000	43%
Burlington and Walworth	268,000	6%
Racine, Kenosha and Northern Illinois	289,000	7%
Behavioral Health[(2)]	N/A	1%

[(1)] Source - 2016 Esri population projections, excluding northern Illinois counties; all numbers are approximates.

[(2)] Behavioral Health not defined by geographical boundaries so population statistics are not applicable.

Facilities

Aurora Hospital Facilities. The Aurora Hospital Facilities include 15 hospitals with 2,014 available beds. Each Aurora Hospital Facility is accredited by The Joint Commission. With the exception of Aurora BayCare Medical Center, the Aurora Hospital Facilities are owned or operated by an entity exempt from federal income taxation by virtue of Sections 501(a) and 501(c) of the Internal Revenue Code of 1986, as amended, and are currently exempt from Wisconsin property taxes. Aurora BayCare Medical Center is owned and operated by BayCare Aurora, LLC ("Aurora BayCare"), a for-profit Wisconsin limited liability company.

The following table summarizes the Aurora Hospital Facilities as of December 31, 2016 categorized by PSM:

Facility/PSM	Location	Licensed Beds	Available Beds
Greater Milwaukee South			
Aurora St. Luke's Medical Center	Milwaukee	938	625
Aurora St. Luke's South Shore	Cudahy	275	104
Aurora West Allis Medical Center	West Allis	350	195
Aurora Sinai Medical Center	Milwaukee	386	157
Sheboygan, Calumet and Greater Milwaukee North			
Aurora Sheboygan Memorial Medical Center	Sheboygan	185	130
Aurora Medical Center Washington County	Hartford	71	35
Aurora Medical Center – Grafton	Grafton	116	116
Greater Green Bay, Manitowoc and Marinette			
Aurora BayCare Medical Center	Green Bay	167	149
Aurora Medical Center Manitowoc County	Two Rivers	69	63
Oshkosh and Fond du Lac			
Aurora Medical Center – Oshkosh	Oshkosh	84	61
Burlington and Walworth			
Aurora Lakeland Medical Center	Elkhorn	109	67
Aurora Memorial Hospital of Burlington	Burlington	123	55
Racine, Kenosha and Northern Illinois			
Aurora Medical Center – Kenosha	Kenosha	74	74
Waukesha and Jefferson			
Aurora Medical Center – Summit	Summit	110	92
Behavioral Health			
Aurora Psychiatric Hospital	Wauwatosa	105	91
Totals		**3,162**	**2,014**

The geographic location of the Aurora Hospital Facilities is illustrated on the map on page 6.

Aurora St. Luke's Medical Center is Aurora's largest facility. As a quaternary hospital, Aurora St. Luke's Medical Center offers a broad range of highly specialized services which include state-of-the-art treatment options such as endovascular cardiac valve surgery, robotically assisted heart surgery, Cyberknife technology and others. For the year ended December 31, 2016, Aurora St. Luke's Medical Center represented 23% of Aurora's total revenue.

Aurora St. Luke's Medical Center was named in the U.S. News & World Report's 2016 best hospital rankings for the Milwaukee area and was nationally recognized in three adult specialties. Aurora St. Luke's Medical Center was also recognized by The American Heart Association and American Stroke Association for its performance in treating cardiac and stroke patients and was one of only 26 hospitals to receive "Triple Recognition." Additionally, Aurora St. Luke's Medical Center was named as one of 100 hospitals and health systems with great oncology programs in 2016 by Becker Hospital review.

Aurora Clinic Facilities. The following table summarizes the clinic facilities operated by Aurora as of December 31, 2016, categorized by PSM.

PSM	Number of Clinic Sites
Greater Milwaukee South	30
Sheboygan, Calumet and Greater Milwaukee North	35
Greater Green Bay, Manitowoc and Marinette	23
Oshkosh and Fond du Lac	12
Burlington and Walworth	14
Racine, Kenosha and Northern Illinois	12
Waukesha and Jefferson	5
Behavioral Health	7
Other Affiliates [(1)]	19
Total	**157**

[(1)] Other affiliates include clinic facilities which are not assigned to a specific PSM.

The Aurora Clinic Facilities include smaller local clinic facilities that focus on primary and preventive health care, in addition to larger specialty facilities, ambulatory surgery centers, and outpatient facilities located at the campuses of the Aurora Hospital Facilities. The breadth of the Aurora Clinic Facilities provides Aurora with the foundation necessary for population health management and allows for delivery of a full continuum of care throughout the communities it serves.

Market Dynamics

As shown in the table below, Aurora is a leader in the Greater Milwaukee South and Waukesha, Sheboygan, Calumet and Greater Milwaukee North, and Burlington and Walworth service areas based on adult acute care admissions. Through December 31, 2016, the Aurora Hospital Facilities in Greater Milwaukee South and Waukesha and Jefferson accounted for approximately 41% of the total PSM adult acute care admissions and approximately 61% of total Aurora adult acute care admissions. During that same period, its share of admissions in the remaining PSM's remained relatively consistent.

The following table summarizes Aurora's percent of adult acute care admissions by PSMs with similar geographic boundaries (or, that contain acute care facilities) for the six months ended June 30, 2016 and the years ended December 31, 2015 and 2014.

Percentage of Adult Acute Care Admissions by PSM

		December 31,	
	June 30, 2016 [1]	**2015**	**2014**
Greater Milwaukee South and Waukesha and Jefferson[2]**:**			
Aurora	41%	40%	39%
Ascension Health	24	25	25
Froedtert & Community Health	24	24	24
ProHealth	11	11	12
	100%	100%	100%
Greater Green Bay and Manitowoc:			
Aurora	30%	30%	30%
Bellin Health	24	24	24
Hospital Sister's Health System	39	38	38
Franciscan Sister of Christian Charity	7	8	8
	100%	100%	100%
Oshkosh and Fond du Lac:			
Aurora	8%	8%	8%
Ascension Health	32	32	32
Agnesian Health	19	18	18
ThedaCare	41	42	42
	100%	100%	100%
Sheboygan, Calumet, and Greater Milwaukee North:			
Aurora	56%	54%	53%
Hospital Sister's Health System	10	10	10
Ascension Health	19	21	22
Froedtert & Community Health	15	15	15
	100%	100%	100%
Burlington and Walworth:			
Aurora	81%	82%	83%
Mercy Health System	19	18	17
	100%	100%	100%
Racine, Kenosha and Northern Illinois [3]**:**			
Aurora	21%	20%	18%
Ascension Health	49	49	50
United Health System [4]	30	31	32
	100%	100%	100%

(1) Source: Wisconsin Hospital Association: Inpatient Admissions - 2016 based on all payer types, including charity care. Most recent data is as of June 30, 2016. The percentages by PSM are based on the site of admission, not the origin of the patient, and accordingly do not reflect those patients residing in an area who receive care outside of such area.

(2) Includes Greater Milwaukee South and Waukesha and Jefferson PSM's.

(3) Aurora does not own or operate a hospital facility in Illinois, so information for northern Illinois has not been included.

(4) United Health System is part of Froedtert & Community Health as of April 2017.

Historical Utilization

The following table summarizes utilization statistics for Aurora for the years ended December 31, 2016, 2015, and 2014:

	Year Ended December 31,		
	2016	**2015**	**2014**
Adult inpatient days	446,257	442,413	435,187
Adult average daily census	1,219	1,212	1,192
Adult average length of stay	4.3	4.4	4.4
Adult discharges	102,858	100,888	98,533
Emergency room visits	397,118	394,607	376,770
Observation and bedded outpatients	38,688	36,925	35,228
Surgical cases	116,196	111,208	107,388
Physician clinic, hospital outpatient and other visits (includes emergency room visits)	7,406,894	7,124,035	6,833,592

Sources of Patient Service Revenue

Patient service revenue earned by Aurora comes from a variety of sources, which differ among the individual facilities and service areas. A substantial portion of the patient service revenue of Aurora is derived from third-party payors that reimburse or pay for the services provided to patients covered by such third parties. These third-party payors include the federal Medicare program, state Medicaid program and commercial insurance carriers, including preferred provider organizations and health maintenance organizations. Many of those programs make payments to Aurora at rates other than the direct charges that Aurora would charge for such services, which rates may be determined other than on the basis of the actual costs incurred in providing services to such patients. Some private insurance carriers reimburse their insureds or make direct payment to hospitals for medical expenses based on billed charges.

Aurora has negotiated long-term contracts with commercial and exchange insurance plans. Currently, approximately 50% of its commercial business is covered by contracts with remaining terms in excess of five years.

The composition of patient service revenue by payor, net of contractual allowances and discounts (before the provision for bad debts), was as follows for the years ended December 31, 2016, 2015, and 2014:

	Year Ended December 31,		
	2016	**2015**	**2014**
Managed Care and all other	65%	63%	62%
Medicare	26	27	28
Medicaid	8	8	9
Self-pay	1	2	1
	100%	100%	100%

The self-pay revenue above includes only revenue from patients without insurance. The revenue related to amounts due from patients for co-insurance and deductibles is included with the primary insurance coverage.

Medical Staff

Aurora has gained patients in its PSM's through strategic growth in employed physicians. Acquisitions of established physician practices throughout eastern Wisconsin contributed to such growth.

By creating a large referral base, Aurora has developed protection against large scale revenue declines. Aurora currently employs approximately 54% of its medical staff, including approximately 1,730 physicians in over 71 different specialties. Total medical staff, including employed physicians, is currently comprised of approximately 3,225 physicians, with just over 68% of the medical staff considered specialists. During 2016, approximately 76% of Aurora's net patient service revenue was generated from employed and closely aligned physician admissions or referrals.

Aurora is focused on redesigning physician compensation and primary care delivery in order to prepare for the changes in reimbursement expected from health care reform.

Employees

As of December 31, 2016, Aurora had approximately 33,000 employees, representing the equivalent of approximately 28,000 full-time staff. Aurora is the largest private employer in the State of Wisconsin. As of December 31, 2016, approximately 83 of Aurora's employees are members of a collective bargaining unit. Management is not aware of any union organizing activities with respect to any of its other employees. Management considers its relationship with employees to be favorable.

Medical Education Programs

Aurora sponsors numerous medical education programs and has affiliation agreements with multiple colleges. There are approximately 564 medical student rotations and 185 residents and fellows receiving training at Aurora facilities annually.

Insurance Programs

General and Professional Liability Insurance Coverage. The Wisconsin Injured Patients and Families Compensation Fund (the "Fund") was created by Section 655.26 of the Wisconsin Statutes to cover professional liability claims against certain Wisconsin health care providers, including hospitals and physicians, to the extent such claims result in awards in excess of defined limits of required primary insurance coverage. Currently, the required primary coverage limits are $1.0 million for each occurrence and $3.0 million for all occurrences in any policy year. Aurora carries the required primary liability insurance coverage for each of its eligible health care affiliates and each individual employed physician through Continental Casualty Company.

The Fund assesses a fee on Wisconsin health care providers on an annual basis in an amount based partially on the Fund's administrative expenses and partially on the loss experience of the particular type of health care provider. Under current Wisconsin law, if a covered health care provider complies with the statutory rules regarding primary insurance coverage, malpractice claimants against the health care provider must look solely to the Fund for the portion of any awards that are in excess of the primary coverage limits and the health care provider cannot be held liable for such amounts. Operation of the Fund is governed by statute, and there can be no assurance that the State of Wisconsin will continue the Fund indefinitely in its present form.

Aurora also has professional liability coverage for its providers and affiliates that do not qualify for Fund coverage, as well as general liability for all of its entities. These coverages provide a number of shared professional liability limits and shared general liability limits totaling $2.0 million per occurrence and $4.0 million annual aggregate for most providers.

As of December 31, 2016, all of Aurora's primary liability insurance policies for general and professional liability are reinsured by Aurora Liability Assurance, Ltd. ("ALA"), a captive insurance company wholly-owned by the Corporation. ALA maintains a reinsurance trust account, which in total represents security required by the reinsurance agreement between ALA and the Continental Casualty Company. As of December 31, 2016, 2015 and 2014, assets held in the trust were $53.8 million, $54.1 million, and $55.3 million, respectively, and the estimated liability for claims, including incurred but not reported, and future servicing costs were $35.2 million, $37.9 million, and $39.2 million, respectively.

Workers' Compensation. The Corporation also provides statutory workers' compensation insurance for employees. As of December 31, 2016, through the workers' compensation insurance policy with Sentry Casualty Company, the Corporation assumed a portion of each workers' compensation claim occurrence up to a stop loss amount. Loss amounts exceeding that amount remain the responsibility of the insurance company. Aurora measures the cost of its unfunded obligations under such programs based upon actuarial estimates and records a liability on a discounted basis.

Other Insurance Coverages. In addition to the insurance programs discussed above, Aurora purchases commercial policies for property, crime, directors' and officers' liability, automobile liability, helipad and non-owned aircraft liability, fiduciary liability, pollution liability, and cyber liability, with varying amounts of coverage and deductibles that it evaluates periodically.

Community Benefit

Aurora operates to benefit the people in the communities it serves and to carry out its purpose, we help people live well. In pursuing its purpose, Aurora advocates for and provides services to help meet health care and related socioeconomic needs of the poor and disadvantaged individuals and the broader community both as an individual organization and in partnership with local health departments, nonprofit agencies, civic organizations and other community agencies. The combination of expertise and shared accountability allows Aurora to advocate for and advance best practices to improve the health of the communities it serves.

Aurora provides health care services without charge to patients who meet the criteria of its charity care policy. The amount of charity care provided, determined on the basis of cost, is estimated based on entity-specific cost-to-charge ratios. In addition to charity care, Aurora provides services to Medicaid and other public programs for financially needy patients, for which the payments received, are less than the cost of providing services. The unpaid costs attributed to providing services under these programs are considered a community benefit.

Aurora is also involved in numerous other wide-ranging community benefit activities that include community health education and outreach in the form of free or low-cost clinics, health education, health promotion and wellness programs, such as health screenings and immunizations, research and innovation, and various community projects, transportation services, and support groups.

A summary of the cost of uncompensated care, community benefits provided, and the unpaid cost of Medicare for the years ended December 31, 2016, 2015, and 2014, is as follows (in thousands):

	2016	2015	2014
Cost of charity care provided	$ 47,477	$ 29,771	$ 64,104
Unpaid cost of Medicaid	335,431	320,475	257,464
Unpaid cost of other public Programs	9,254	9,452	9,650
Total cost of uncompensated care	392,162	359,698	331,218
Community health improvement, education services and community benefit operations	10,973	7,865	11,152
Health professional education	8,919	10,463	10,768
Subsidized health services	5,996	9,255	13,013
Cash and in-kind contributions for community benefit	7,258	8,149	5,700
Total community benefit programs	33,146	35,732	40,633
Unpaid cost of Medicare	645,988	579,806	472,823
Total cost of uncompensated care, community benefit programs, and unpaid cost of Medicare	$ 1,071,296	$ 975,236	$ 844,674

Aurora in partnership with the Greater Milwaukee Foundation established the "Better Together Fund" to focus on specific areas of community need. In 2015, Aurora made a $3.8 million contribution of cash and in-kind contributions to support health initiatives in the communities it serves through the fund. This contribution supported community health centers and other organizations in eastern Wisconsin to improve access to primary and behavioral health care as well as treatment and prevention programs for sexual assault and domestic violence. In 2016, Aurora made additional contributions to the "Better Together Fund" of $5.0 million.

Licensure, Certification and Accreditation

Each of the Aurora Hospital Facilities is licensed as a Wisconsin hospital and is certified to participate in the Medicare program and the State of Wisconsin's Medicaid program, and each is accredited by The Joint Commission.

Legal and Regulatory Compliance

Aurora operates in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings are instituted or asserted against it from time to time. The results of claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, could have a material adverse effect on Aurora's consolidated financial position or results of operations.

Compliance and Internal Audit Programs

Aurora has a corporate compliance department and maintains a corporate compliance program intended to be consistent with laws and government guidance relating to compliance programs in health care entities. The program includes mandatory education of all employees about certain significant legal and regulatory requirements applicable to the organization, including HIPAA and other privacy regulations, and includes steps to monitor and promote compliance with these requirements. All employees are provided a copy of the Aurora Code of Ethical Conduct and sign a document acknowledging they have read it and understand it reflects Aurora's policy. A "hotline" is available to all employees and physicians to report any areas of potential concern. In addition, Aurora has adopted policies designed to address specific risk areas and has instituted processes intended to correct problems identified through the hotline or its other compliance activities. The corporate compliance department reports functionally to the Chief Administrative Officer and administratively to the Audit and Compliance Committee to the Board of Directors.

Aurora also has an internal audit department responsible for providing independent and objective assurance and consulting services designed to add value and improve Aurora's operations and control environment. The internal audit department reports functionally to the Chief Administrative Officer and administratively to the Audit and Compliance Committee to the Board of Directors. The responsibilities of the internal audit department include assessing the effectiveness of internal controls, reviewing compliance with applicable laws and regulations and assessing the reliability of financial reporting.

Debt Compliance Program

Aurora has adopted a debt compliance policy, which establishes uniform guidelines in connection with its tax-exempt bonds and other financial arrangements. The purpose of the policy is to ensure compliance with all federal tax laws relating to tax-exempt bonds including, but not limited to, rules relating to ownership and use of bond-financed property and investment of bond proceeds; compliance with all securities laws relating to Aurora and its bonds including ongoing public disclosure requirements and compliance with all financial and other covenants imposed under the Master Indenture, loan agreements and other agreements related to its bonds and financial arrangements. Preparing and maintaining documentation necessary to provide a record of compliance is an integral aspect of the policy.

Internal Control Over Financial Reporting Program

Aurora continues to strengthen and improve its internal control environment and create efficiencies in the financial reporting process. Aurora's internal controls program is based upon concepts established in the Sarbanes-Oxley Act of 2002 ("SOX"), even though Aurora is not subject to the provisions of SOX. The internal controls program is focused on ensuring the integrity and reliability of financial information, strengthening internal controls in the reporting process, reducing the risk of fraud and increasing efficiencies in the financial reporting process. The program includes the review of all aspects of the financial reporting process, identification of potential risks and ensure the risks have been mitigated utilizing a management self-assessment process.

SELECTED FINANCIAL INFORMATION OF AURORA

The following condensed consolidated financial information of Aurora as of and for each of the three years ended December 31, 2016, 2015 and 2014, has been derived from the audited consolidated financial statements of Aurora and should be read in conjunction with the audited consolidated financial statements of Aurora as of and for the years ended December 31, 2016, 2015 and 2014, and the related notes thereto. The audited consolidated financial statements are available from the Municipal Securities Rulemaking Board (the "MSRB") on its Electronic Municipal Market Access ("EMMA") system, found at http://emma.msrb.org.

Additional information can be obtained from the Investor Relations section within Aurora's website found at https://www.aurorahealthcare.org/about-aurora/investor-relations-financial-information.

Aurora Health Care, Inc. and Affiliates
Condensed Consolidated Balance Sheet Information
(In thousands)

	December 31,		
	2016	**2015**	**2014**
Cash and cash equivalents	$ 107,664	$ 176,626	$ 238,772
Investments	1,614,843	1,272,107	1,157,604
Assets whose use is limited or restricted	5,484	10,793	5,560
Patient accounts receivable — net	731,746	760,058	613,971
Other receivables	102,791	81,626	74,490
Inventory	70,031	67,572	64,805
Prepaids and other current assets	48,026	56,728	39,885
Estimated third-party payor settlements	9,989	7,494	9,361
Total current assets	2,690,574	2,433,004	2,204,448
Assets whose use is limited or restricted	398,048	375,551	381,003
Property, plant, and equipment, net	2,066,286	1,955,988	1,869,492
Intangible assets — net	15,786	16,245	18,884
Investments in unconsolidated entities	72,313	73,788	66,135
Other assets	56,835	48,410	41,484
Total Assets	$ 5,299,842	$ 4,902,986	$ 4,581,446
Current installments of long-term debt	$ 161,936	$ 136,542	$ 56,882
Accounts payable	222,528	228,344	201,593
Accrued salaries and wages	259,225	277,070	310,848
Other accrued expenses	213,684	203,344	179,804
Estimated third-party payor settlements	34,041	22,061	22,446
Total current liabilities	891,414	867,361	771,573
Long-term debt, less current installments	1,403,091	1,421,061	1,557,352
Pension and other employee benefit liabilities	243,574	225,428	282,442
Self-insured liabilities	61,592	64,898	63,934
Deferred gain	36,662	41,863	47,364
Other	61,822	65,191	67,360
Total liabilities	2,698,155	2,685,802	2,790,025
Unrestricted net assets:			
Controlling interest	2,439,653	2,066,225	1,639,621
Noncontrolling interest in subsidiaries	100,119	88,447	86,631
Total unrestricted net assets	2,539,772	2,154,672	1,726,252
Temporarily restricted net assets	43,171	43,779	46,697
Permanently restricted net assets	18,744	18,733	18,472
Total net assets	2,601,687	2,217,184	1,791,421
Total Liabilities and Net Assets	$ 5,299,842	$ 4,902,986	$ 4,581,446

Aurora Health Care, Inc. and Affiliates
Condensed Consolidated Statements of Operations and Changes in Unrestricted Net Assets
(In thousands)

	Year Ended December 31,		
	2016	**2015**	**2014**
REVENUE:			
Patient service revenue	$ 4,837,262	$ 4,647,940	$ 4,361,800
Less provision for bad debts	140,151	132,805	56,402
Net patient service revenue	4,697,111	4,515,135	4,305,398
Other revenue	427,702	414,912	410,695
Total revenue	5,124,813	4,930,047	4,716,093
EXPENSES:			
Salaries wages and fringe benefits	2,805,198	2,564,106	2,465,092
Professional fees	82,707	79,893	75,527
Supplies	987,058	929,228	818,862
Depreciation and amortization	207,842	198,644	205,798
Interest	57,687	57,378	63,602
Maintenance and service contracts	119,659	111,637	100,623
Building and equipment rental	65,850	71,087	76,892
Hospital tax assessment	97,201	94,739	94,396
Utilities	48,751	47,118	47,690
Purchased services	137,940	123,854	112,785
Other expenses	141,582	153,111	151,801
Pension settlement loss	—	36,848	—
Total expenses	4,751,475	4,467,643	4,213,068
OPERATING INCOME	373,338	462,404	503,025
NONOPERATING INCOME (LOSS):			
Investment income	95,603	(1,949)	35,341
Other nonoperating income (loss) - net	202	(17,725)	758
Total nonoperating income (loss) — net	95,805	(19,674)	36,099
Excess of revenue over expenses [(1)]	469,143	442,730	539,124
Pension-related changes other than periodic pension cost	(49,680)	25,234	(113,706)
Net assets released from restriction for purchase of property and equipment	3,292	2,643	1,341
Distributions to noncontrolling interests	(37,277)	(42,581)	(39,260)
Other	(378)	394	(89)
Increase in unrestricted net assets	$ 385,100	$ 428,420	$ 387,410

(1) Aurora Medical Group has a majority (approximately 62%) interest in Aurora BayCare. Additionally, the Corporation has a controlling financial interest in three surgery centers. The accounts of Aurora BayCare and the three surgery centers are included in the consolidated financial statements of Aurora. Excess of revenue over expenses includes $48.9 million, $44.4 million, and $48.4 million for the years ended December 31, 2016, 2015, and 2014, respectively, attributable to the noncontrolling interests in Aurora BayCare and the surgery centers.

Financial Ratios

The financial ratios presented below reflect the consolidated results of Aurora as of and for the years ended December 31, 2016, 2015, and 2014:

	Year Ended December 31,		
	2016	**2015**	**2014**
Operating Performance:			
Operating margin (1)	7.3%	9.4%	10.7%
EBIDA percent (2)	14.3%	14.2%	17.1%

	As of December 31,		
	2016	**2015**	**2014**
Liquidity:			
Days cash on hand [3]	152.0	137.4	141.8
Net AR days outstanding [4]	57.0	61.4	52.1
Financial Position/Leverage Ratios:			
Unrestricted cash to debt [5]	121%	103%	96%
Cash to puttable debt [6]	390%	327%	341%
Debt to capitalization [7]	38%	42%	49%
Debt to cash flow [8]	2.3	2.4	2.2
Debt service coverage ratio [9]	5.9x	6.0x	6.8x

[1] Operating income /Total revenue.

[2] (Excess of revenues over expenses + Interest expense + Depreciation and amortization expense)/Total revenue.

[3] (Unrestricted cash and investments)/((Total expenses – Depreciation and amortization expense)/actual number of days in a period).

[4] Accounts receivable, net/(Net patient service revenue/actual number of days in a period).

[5] (Unrestricted cash and investments)/(Current installments of long-term debt + Long-term debt, less current installments).

[6] (Unrestricted cash and investments)/Total variable rate demand bonds outstanding.

[7] (Current installments of long-term debt + Long-term debt, less current installments)/ (Current installments of long-term debt + Long-term debt, less current installments + Total Unrestricted net assets).

[8] (Current installments of long-term debt + Long-term debt, less current installments)/ (Excess of revenue over expenses + Depreciation and amortization expense).

[9] (Excess of revenues over expenses + Interest expense + Depreciation and amortization expense)/(Principal payments + Interest expense).

The Obligated Group

The Obligated Group includes the Corporation and the affiliates below. Each member of the Obligated Group agreed to be jointly and severally obligated for Master Notes issued under the Master Indenture. The Corporation does not currently expect to change the composition of the Obligated Group.

The Obligated Group

- Aurora Health Care, Inc.
- Aurora Health Care Metro, Inc.
- Aurora Health Care Central, Inc.
- Aurora Health Care Southern Lakes, Inc.
- Aurora Medical Center of Washington County, Inc.
- Aurora Health Care North, Inc.
- Aurora Medical Center of Oshkosh, Inc.
- Aurora Medical Group, Inc.
- Aurora Medical Center Grafton, LLC

The Obligated Group operates 13 of Aurora's 15 Hospital Facilities and 121 of Aurora's 157 Clinic Facilities.

Obligated Group and Non-Obligated Group Financial Information:

The information provided for the Obligated Group as of and for the years ended December 31, 2016, 2015 and 2014 is derived from the unaudited consolidating financial information underlying the audited consolidated financial statements of Aurora. The Obligated Group select financial information below includes all adjustments that management considers necessary to present such information in conformity with GAAP applied on a basis substantially consistent with that of the audited consolidated financial statements.

The financial information for the Obligated Group includes the financial results of certain wholly and partially owned or controlled entities of Aurora which have not assumed any financial obligation related to payment of or security for any notes issued under the Master Indenture ("Non-Member Entities") but are recognized as investment interests of the Obligated Group in accordance with GAAP.

The aggregate total revenue, total assets, and total net assets of the Obligated Group and Non-Obligated Group Entities as of and for the years ended December 31, 2016, 2015, and 2014, is as follows (in thousands):

	December 31,					
	2016		2015		2014	
Total Revenue						
Obligated Group	$ 3,660,311	71%	$ 3,524,330	71%	$ 3,388,261	72%
Non-Obligated Group	1,464,502	29%	1,405,717	29%	1,327,832	28%
Consolidated System	$ 5,124,813	100%	$ 4,930,047	100%	$ 4,716,093	100%
Total Assets [(1)(2)]						
Obligated Group	$ 4,547,232	86%	$ 4,151,474	85%	$ 3,922,401	86%
Non-Obligated Group	752,610	14%	751,512	15%	659,045	14%
Consolidated System	$ 5,299,842	100%	$ 4,902,986	100%	$ 4,581,446	100%
Total Net Assets [(1)(2)]						
Obligated Group	$ 1,929,714	74%	$ 1,599,011	72%	$ 1,223,637	68%
Non-Obligated Group	671,973	26%	618,173	28%	567,784	32%
Consolidated System	$ 2,601,687	100%	$ 2,217,184	100%	$ 1,791,421	100%

(1) The selected financial information has been prepared pursuant to the provisions of the Master Indenture. Such information reflects the Obligated Group as defined in the Master Indenture, with the exception of the Obligated Group Members' investment in certain Non-Member Entities whose stock is wholly or majority owned by an Obligated Group member and the net assets of charitable foundations set forth in footnote (2). The total net assets of these wholly or majority owned Non-Member Entities are $242.3 million, $239.8 million, and $170.9 million as of December 31, 2016, 2015, and 2014, respectively. Such amounts have been included in the total assets of the Obligated Group in the Selected Financial Information above.

(2) Certain Obligated Group Members have ownership interests in the net assets of charitable foundations that raise funds on behalf of Aurora. The total net assets of these foundations are $158.3 million, $152.5 million, and $191.8 million as of December 31, 2016, 2015, and 2014, respectively. Such amounts have been included in the total assets of the Obligated Group in the Selected Financial Information above.

MANAGEMENT DISCUSSION AND ANALYSIS OF RESULTS OF OPERATIONS

Results of Operations – Year Ended December 31, 2016 Compared to Year Ended December 31, 2015
Operating income was $373.3 million in 2016, resulting in an operating margin of 7.3%, as compared to operating income of $462.4 million and an operating margin of 9.4% in 2015. The decrease in operating income period over period relates primarily to increases in salaries wages and fringe benefits, supplies expense and purchased services, offset by an increase in total revenue during the period. These trends are discussed in further detail below. Nonoperating income was $95.8 million in 2016 compared to $19.7 million of nonoperating loss for the same period in 2015. The increase from prior year is due to favorable market conditions which results in a $91.0 million increase in unrealized gains for the year ended December 31, 2016 compared to year ended December 31, 2015. Additionally, other nonoperating income increased due to one time activity in 2015 including a $25.3 million loss on the disposal of fixed assets as a result of the completion of a comprehensive fixed asset physical inventory, which was offset by a $9.2 million gain on the sale of the Marinette surgery center. Overall, Aurora reported an excess of revenue over expenses of $469.1 million in 2016 compared to $442.7 million in 2015.

Patient service revenue increased $189.3 million (4.1%) in the year ended December 31, 2016, compared to the same period in 2015. The increase in revenue was due to higher volumes than prior year, most significantly observation and bedded outpatients, surgical cases, physician clinic, hospital outpatient and other visits, and adult discharges which increased 4.8%, 4.5%, 4.0%, and 2.0%, respectively, offset by an increase in charity care. Charity care as a percentage of gross patient service revenue increased from 0.7% for the year ended December 31, 2015 to 1.1% for the year ended December 31, 2016, due to the automation of the process to identify patients who qualify for charity care which has resulted in more write-offs as charity care.

Provision for bad debts increased $7.3 million (5.5%) in the year ended December 31, 2016, compared to the same period in the prior year. The increase in the provision for bad debt was primarily due to an increase in volumes and corresponding revenues period over period. Bad debt as a percentage of patient service revenue was consistent with prior year at 0.9% for the years ended December 31, 2016 and December 31, 2015.

Other revenue increased $12.8 million (3.1%) for the year ended December 31, 2016, compared to the same period in the prior year. This increase was primarily driven by a $22.9 million increase in favorable risk share, quality, and administrative revenue related to managed care agreements. Other revenue also increased $10.2 million due to investment income on certain defined contribution funds due to favorable market conditions and an increase in the fund balances. These increases were offset by a decrease in 340B contract pharmacy revenue of $25.6 million, due to a current year change in the determination of a qualifying prescription under the 340B program.

Operating expenses, excluding depreciation and amortization, interest, other and pension settlement loss, as a percentage of total revenue, increased from 82% in 2015 to 85% in 2016.

Salaries, wages and fringe benefits expense increased $241.1 million (9.4%) for the year ended December 31, 2016, compared to the same period in the prior year. Salaries and wages expense increased

$186.3 million during the period. This increase was driven by a 6% increase in full time equivalents ("FTE's") year over year and the annual merit increase of 2.9% which was effective in July 2016. Fringe benefits expense increased $56.1 million compared to the prior period due to an increase in employee related benefits such as FICA, 401(k) and health insurance costs.

Supplies expense increased $57.8 million (6.2%) in the year ended December 31, 2016, compared to the same period in the prior year. The increase in supplies expense is primarily due to the increase in volume from the prior year. The increase in supplies is also due to higher drug and implant expense which increased $12.1 million and $9.1 million, respectively. Drug and implant costs were impacted by increased volumes and price increases as well as the increased use of higher cost specialty drugs and more expensive cardiac and orthopedic implants. Supplies expense as a percent of total revenue has increased from 18.8% for the year December 31, 2015 to 19.3% for the year ended December 31, 2016 due to the cost increases discussed above.

Depreciation increased $9.2 million (4.6%) in the year ended December 31, 2016, compared to the same period in the prior year. This increase was due to capital expenditures during the current year, as well as the acceleration of depreciation on the apartments adjacent to the Aurora West Allis Medical center, which were demolished in 2016 to make way for the expansion of the parking structure.

Maintenance and service contracts increased $8.0 million (7.2%) in the year ended December 31, 2016, compared to the same period in the prior year. This increase is due to service contracts associated with additional IT equipment to support a new data center and other operations.

All other expenses, including professional fees, interest, building and equipment rental, hospital tax assessment, utilities, purchased services, and other expenses remained consistent in the year ended December 31, 2016 as compared to the year ended December 31, 2015, increasing $4.5 million (0.7%) in the aggregate.

Results of Operations – Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

Operating income was $462.4 million in 2015, resulting in an operating margin of 9.4%, as compared to operating income of $503.0 million and an operating margin of 10.7% in 2014. The lower operating income in 2015 was primarily due to higher supply costs and a $36.8 million pension settlement loss, as further discussed below. Nonoperating loss was $19.7 million in 2015 compared to $36.1 million of nonoperating income in 2014. The decrease from the prior year was due to a decrease in investment income as a result of a change in the mix of investments held in Aurora's investment portfolio to a higher concentration of equity securities which were impacted by overall changes in the financial markets. The decrease in nonoperating income was also due to a $25.3 million loss on the disposal of fixed assets as a result of the completion of a comprehensive fixed asset physical inventory during 2015 offset by a gain on the sale of the Marinette surgery center of $9.2 million. Overall, Aurora reported an excess of revenue over expenses from continuing operations of $442.7 million in 2015 compared to $539.1 million for the same period in the prior year.

Patient service revenue increased $286.1 million (6.6%) in the year ended December 31, 2015, compared to the same period in 2014. This increase was due to higher volumes than prior year, most significantly

emergency room visits, observation and bedded outpatients, physician clinic, hospital outpatient and other visits, and surgical cases which increased 5.4%, 4.8%, 4.3%, and 3.6%, respectively.

Provision for bad debts increased $76.4 million (135.5%) in the year ended December 31, 2015, compared to the same period in the prior year. Charity care and bad debt as a percentage of patient service revenue have decreased from 6.2% for the year ended December 31, 2014 to 5.1% for the year ended December 31, 2015. The increase in the provision for bad debts is due to the reclassification of certain write-offs from charity care to bad debt as part of the implementation of the Internal Revenue Service Regulation 501(r).

Other revenue remained consistent increasing $4.2 million (1.0%) for the year ended December 31, 2015, compared to the same period in the prior year. Other revenue increased primarily due to increased pharmacy revenue under the 340B program offset by investment losses related to certain defined contribution funds, a decrease in Hitech revenue and lower retail pharmacy sales.

Operating expenses, excluding depreciation and amortization, interest, other and pension settlement loss, as a percentage of total revenue, remained relatively consistent at 82% and 80% in 2015 and 2014, respectively.

Salaries, wages and fringe benefits expense increased $99.0 million (4.0%) for the year ended December 31, 2015, compared to the same period in the prior year. Salaries and wages expense increased $130.8 million primarily due to a 5.2% increase in full time equivalents as compared to prior period which is consistent with the increase in volumes noted above. Fringe benefits expense decreased compared to prior period due to lower health insurance costs.

Supplies expense increased $110.4 million (13.5%) in the year ended December 31, 2015, compared to the same period in the prior year. The increase in supplies expense is primarily due to higher drug and implant expense which increased $86.1 million and $14.1 million, respectively. Drug and implant costs were impacted by increased volumes and price increases as well as the increased use of higher cost specialty drugs and more expensive cardiac and orthopedic implants. Minor equipment expense also increased $13.7 million due to the acceleration of planned repairs and maintenance. Supplies expense as a percent of patient service revenue has increased from 18.8% for the year December 31, 2014 to 20.0% for the year ended December 31, 2015 due to the cost increases discussed above.

During 2015, an option was provided to all terminated, vested participants of the Pension Plan to receive a lump sum settlement. Certain participants elected this option which was measured and paid on December 1, 2015. This settlement resulted in a reduction to the projected benefit obligation of $129.3 million and a settlement loss of $36.8 million.

All other expenses, including professional fees, depreciation and amortization, interest, maintenance and service contracts, building and equipment rental, hospital tax assessment, utilities, purchased services, and other expenses remained consistent in the year ended December 31, 2015 as compared to the year ended December 31, 2014, decreasing $8.3 million (0.9%) in the aggregate.

ANALYSIS OF FINANCIAL CONDITION

Liquidity – Cash and Investments

Aurora's objectives for its investment portfolios are to target returns over the long-term within management determined reasonable and prudent levels of risk and to preserve and enhance its financial structure. The asset allocation of the portfolios, in aggregate, is broadly diversified across domestic and international equity, fixed income asset classes and cash equivalents and is designed to maximize the probability of achieving the long-term investment objectives at an appropriate level of risk while maintaining a level of liquidity to meet current business requirements. Portfolio performance is monitored throughout the year by comparing actual results to specific asset class appropriate benchmarks.

Pension plan investments are primarily maintained in a master trust fund administered using a bank as trustee. All other investments are held in bank accounts whereby the bank provides custody and safekeeping services. Management of Aurora's investments is conducted by external investment management organizations that are monitored by an investment committee to Aurora's Board of Directors, management and a third-party external advisor. Aurora has established formal investment policies that support Aurora's investment objectives.

The following table sets forth the allocation of Aurora's cash and cash equivalents, investments, and assets whose use is limited or restricted as of December 31, 2016, 2015, and 2014 (dollars in thousands):

	December 31,					
	2016		2015		2014	
Cash and cash equivalents	$ 132,659	6.2%	$ 203,057	11.1%	$ 268,499	15.1%
Fixed-income securities:						
U.S. Treasury	94,596	4.4%	80,456	4.4%	81,179	4.6%
Corporate bonds and other debt securities	194,651	9.2%	187,999	10.2%	217,598	12.2%
Federal agency	97,665	4.6%	89,889	4.9%	106,355	6.0%
Fixed income mutual funds	990,518	46.6%	793,033	43.2%	894,656	50.2%
Domestic equity securities:						
Large-cap	17,961	0.8%	16,156	0.9%	20,533	1.2%
Mid-cap	19,257	0.9%	11,006	0.6%	10,977	0.6%
Small-cap	22,106	1.0%	19,124	1.0%	21,794	1.2%
Real estate	470	—%	279	—%	332	—%
Equity mutual funds and exchange-traded funds	384,410	18.1%	300,598	16.4%	80,435	4.5%
Real estate investments	13,953	0.7%	12,774	0.7%	11,042	0.6%
International equity securities	142,192	6.7%	107,183	5.8%	52,730	3.0%
International equity limited partnerships	8,497	0.4%	7,840	0.4%	9,691	0.5%
Other	7,104	0.3%	5,683	0.3%	7,118	0.4%
Total	2,126,039		1,835,077		1,782,939	
Less restricted investments [1]	(239,364)		(232,852)		(226,156)	
Total unrestricted cash and investments	$ 1,886,675		$ 1,602,225		$ 1,556,783	
Days cash on hand [2]	152.0		137.4		141.8	

[1] Restricted investments include donor restricted funds, contractually restricted funds and funds held by a trustee

[2] Days cash on hand is calculated in accordance with Aurora's internal financial reporting methodology. Is not intended to conform to the Master Indenture calculation. See "Covenant Compliance" below.

Aurora's unrestricted cash and investments increased by $284.5 million or 17.8% from December 31, 2015 to December 31, 2016. The increase in unrestricted cash and investments was primarily due to $620.5 million of cash flow generated from operations, $218.0 million of proceeds from long-term debt, offset by $215.6 million of payments on long-term debt, $39.3 million of distributions to minority shareholders, and $346.7 million in capital expenditures.

Aurora's unrestricted cash and investments increased by $45.4 million or 2.9% from December 31, 2014 to December 31, 2015. The increase in unrestricted cash and investments was primarily due to $475.3 million of cash flow generated from operations offset by a net $60.2 million of scheduled principal payments on long-term debt, $35.3 million of distributions to minority shareholders and $296.7 million of capital expenditures.

All investment income or loss is included in nonoperating income (loss), other than investment income or loss on funds held for professional liability coverage, certain employee benefit investments and any donor restricted investment income or loss.

Total investment income (loss) for the years ended December 31, 2016, 2015, and 2014 consisted of the following (in thousands):

	2016	2015	2014
Interest income and dividends	$ 47,454	$ 41,179	$ 30,225
Net realized gains on securities	2,547	3,442	11,358
Changes in unrealized gains (losses) on investments	59,827	(47,351)	2,431
Total	$109,828	$ (2,730)	$ 44,014

Liquidity – Accounts Receivable

Net accounts receivable days outstanding decreased from 61.4 days as of December 31, 2015 to 57.0 days as of December 31, 2016. The primary reason for the decrease in net accounts receivable days outstanding was due to resolution of billing delays related to coding issues as a result of ICD-10 which were present at December 31, 2015, which were no longer present at December 31, 2016.

Net accounts receivable days outstanding increased from 52.1 days at December 31, 2014 to 61.4 days at December 31, 2015. The primary reason for the increase in net accounts receivable days outstanding was a delay in the issuance of bills due to coding issues as a result of ICD-10.

Indebtedness

Master Indenture Obligations: The Corporation has certain outstanding long-term indebtedness in the form of revenue bonds issued by the Wisconsin Health and Educational Facilities Authority on its behalf (the "Revenue Bonds"). The Corporation's obligation to pay debt service on the Revenue Bonds is secured by Master Notes issued under the Master Indenture. The obligations of Aurora to repay advances made under the J.P. Morgan Line of Credit and the Letters of Credit described below are also secured by Obligations issued under the Master Indenture.

At December 31, 2016, 2015 and 2014, the aggregate principal amount of the Revenue Bonds outstanding was as follows (in thousands):

	2016	2015	2014
Fixed rate revenue bonds	$ 582,676	$ 692,737	$ 764,774
Long-term rate revenue bonds	65,000	132,475	132,475
Variable rate revenue bonds	443,490	449,705	456,725
Total	$ 1,091,166	$ 1,274,917	$ 1,353,974

Fixed Rate Revenue Bonds: At December 31, 2016, 2015, and 2014, the Corporation had outstanding $582.7 million (including $11.8 million of unamortized original premium, net), $692.7 million (including $12.7 million of unamortized original premium, net), and $764.8 million (including $14.0 million of unamortized original premium, net) of Fixed Rate Bonds, respectively. The weighted average interest rate on the Fixed Rate Revenue Bonds was 4.89%, 5.14%, and 5.12% at December 31, 2016, 2015, and 2014, respectively.

Long-Term Rate Bonds: Long-Term Rate Bonds bear interest at fixed rates for specified periods, and are subject to mandatory tender at the end of such periods, on the date and in the principal amount described below. Failure of the Corporation to pay the purchase price on the applicable tender date would constitute an event of default under the related bond documents.

Series	Principal Amount	Mandatory Tender Date
Series 2009B-1	$65,000	August 15, 2017

There is no liquidity facility in effect with respect to the long-term rate bonds to pay the purchase price on the mandatory tender date. Without a liquidity facility dedicated to these bonds, the bond holder is required to put these bonds to Aurora on the mandatory tender date. At December 31, 2016, $65.0 million of the long-term bonds are classified as current due to these requirements.

Variable Rate Demand Bonds ("VRDBs"): The VRDBs bear interest at variable rates (currently in daily, weekly, or Unit Pricing interest rate modes) and are subject to optional tender for purchase by their holders. At December 31, 2016, all of the VRDBs are secured by Letters of Credit issued by commercial banks (the "Letters of Credit"). Subject to certain requirements in the related Reimbursement Agreements, the Letters of Credit may be drawn on to pay the tenders of the VRDBs in the event they are not remarketed. For $327.3 million of the letters of credit, principal payments are due quarterly, beginning the earlier of one year from the date of the advance or two months after the expiration date of the letter of credit and amortize over a three-year period, not to exceed three years from the letter of credit's stated expiration date. For the remaining $133.3 million letters of credit, principal payments are due quarterly, beginning the earlier of one year from the date of the advance or two months after the expiration date of the letter of credit and amortize over a two-year period, not to exceed two years from the letter of credit's stated expiration date. Each Letter of Credit is subject to extension of its expiration date at the sole discretion of the related commercial bank.

Bank	Par (in thousands)	Expiration
J.P. Morgan	$ 50,822	09/29/2017
J.P. Morgan	84,384	09/29/2017
J.P. Morgan	83,825	09/29/2017
Bank of Montreal	38,270	2/7/2018
Bank of Montreal	38,270	2/7/2018
Bank of Montreal	56,776	2/7/2018
Bank of America	108,301	01/31/2019
Total	$ 460,648	

Line of Credit. At December 31, 2016, 2015, and 2014, the Corporation had a $60.0 million line of credit, under which letters of credit can also be issued, with J.P. Morgan Chase Bank, N.A., bearing interest at the commercial bank floating rate or LIBOR plus a spread, based upon the option of the Corporation. As of December 31, 2016, 2015, and 2014, two letters of credit issued under the line of credit totaling $38.8 million, $37.7 million, and $36.3 million were outstanding. There are currently no outstanding draws on the line of credit or letters of credit.

Other Indebtedness. Aurora is obligated under capital lease and financing arrangements entered into in connection with certain sale-leaseback transactions which are reflected as long-term debt in the consolidated financial statements of Aurora. These arrangements, which relate to various administrative and medical support buildings, had initial lease terms of 15 to 25 years. At December 31, 2016, 2015, and 2014, the outstanding amount of capital lease obligations and financing arrangements was $220.8 million, $239.6 million, and $256.5 million, respectively.

At December 31, 2015, Aurora was obligated under a term note. The term note was an obligation of Aurora BayCare and was collateralized by a mortgage on the orthopedic and sports medicine complex

and a pledge of Aurora BayCare's interest in, and proceeds from, certain lease agreements, and required monthly principal and interest payments at LIBOR, plus 1.375%. The Term Note was paid off in 2016.

Taxable Bonds. On August 15, 2016, Aurora issued $218.0 million of Series 2016A and 2016B fixed rate taxable bonds which were directly placed with two commercial banks. The proceeds of the 2016A and 2016B Bonds were used to redeem $81.2 million of the Series 1993 Fixed Rate Revenue Bonds, $67.5 million of the Series 2009B-2 Fixed Rate Revenue Bonds and pay off the balance on the term note of $9.8 million. The remaining proceeds will be used primarily to fund various capital projects.

On April 15, 2015, Aurora redeemed $40.0 million of Series 2010A Fixed Rate Revenue Bonds with the proceeds of its Aurora Health Care, Inc. Taxable Bonds (the "2015A Bonds"). The 2015A Bonds were a direct placement and bear interest at a taxable, variable rate. The 2015A Bonds are subject to a mandatory tender on April 15, 2018.

Aurora's total long-term debt at December 31, 2016, 2015, and 2014 is as follows (in thousands):

	December 31,		
	2016	**2015**	**2014**
Total revenue bonds	$ 1,091,166	$ 1,274,917	$ 1,353,974
Capital lease obligations and financing arrangements	220,829	239,646	256,526
Taxable bonds	258,000	40,000	—
Term note	—	10,264	11,075
Various notes payable	5,943	6,573	8,398
Deferred financing costs - net	(10,911)	(13,797)	(15,739)
Total long-term debt	$ 1,565,027	$ 1,557,603	$ 1,614,234

Interest Rate Swap Agreement

Aurora had a fixed-to-variable interest rate swap agreement (the "Swap Agreement") with Merrill Lynch Capital Services, Inc. ("MLCS") with respect to the Wisconsin Health and Educational Facilities Authority Revenue Bonds, Series 1993, (the "Series 1993 Bonds"). The Swap Agreement was terminated in August 2016 in connection with the redemption of the Series 1993 Bonds. During the term of the Swap Agreement, Aurora continued to pay interest on the Series 1993 Bonds at their fixed interest rates, and paid MLCS a variable-rate based on the Securities Industry and Financial Markets Association Index (SIFMA) plus a spread calculated on a notional amount equal to the principal amount of the Series 1993 Bonds outstanding plus a premium. In turn, Aurora received fixed-rate payments from MLCS based on a notional amount equal to the principal amount of the Series 1993 Bonds outstanding. At December 31, 2015 and 2014 the fair value of the Swap Agreement was a liability of $2.4 million and $2.6 million, respectively.

As of December 31, 2015 and 2014, no collateral was required. The Corporation received net swap payments of $2.2 million, $3.9 million and $3.9 million during the years ended December 31, 2016, 2015, and 2014, respectively.

Capital Expenditures

In 2016, 2015, and 2014, Aurora's capital expenditures were $346.7 million, $296.7 million, and $172.3 million, respectively. The increase in capital expenditures since 2014 reflects Aurora's focus on strategic capabilities and growth. In the last several years, a large part of Aurora's capital allocation was directed at facility repositioning and information technology. Consistent with its strategic initiatives, Aurora's capital expenditures in 2016 and those budgeted for 2017 reflect a continued shift in capital allocation from information technology to strategic capabilities and growth, as represented by funding for a planned ambulatory surgery center in Kenosha, a planned replacement hospital and ambulatory surgery center in Sheboygan, and a planned ambulatory surgery center in greater Milwaukee south. Anticipated capital expenditures for these projects are $122.0 million for the Kenosha ambulatory surgery center, $308.0 million for the Sheboygan projects, and $55.5 million for the greater Milwaukee south ambulatory surgery center. The expenditures for these projects will extend from 2017 through 2021. Although we continue to invest in information technology we anticipate that more of these costs will be expensed in 2017 as we move to more software as a service.

	Actual 2016	Budget 2017
Strategic capabilities and growth	9.0%	33.0%
Routine replacement	36.0%	24.0%
Information technology	10.0%	9.0%
System (Diagnostic, Facilities & Nursing)	45.0%	34.0%
Total capital expenditures	100%	100%

Historically, Aurora has funded the majority of its capital needs from both excess cash derived from operations and the proceeds of long-term indebtedness. Annual capital expenditures are expected to be approximately $387.2 million in 2017, exclusive of merger and acquisition activity.

The capital budget reflects Aurora's plan to strategically invest in various sites and services, as well as to expand and upgrade existing infrastructure and invest in strategic capabilities and growth. The capital spending plans are based upon budgeted operating performance during those periods, so actual capital expenditures in the period may vary significantly from these expected amounts. Aurora currently expects its affiliates to satisfy certain financial targets and cash flow requirements before extending commitments for capital expenditures.

Retirement Plans

Aurora maintains a noncontributory, defined benefit pension plan (the "Pension Plan") covering substantially all of its employees hired before January 1, 2013, with at least 1,000 hours of work in a calendar year. Benefits in the Pension Plan are based on years of service and the employee's final average earnings, as defined. At a minimum the Corporation funds the amount calculated by the Pension Plan's consulting actuaries to meet the minimum Employee Retirement Income Security Act ("ERISA") funding requirements. The Pension Plan was frozen on December 31, 2012.

During 2015, an option was provided to all terminated, vested participants of the Pension Plan to receive a lump sum settlement. Certain participants elected this option which was measured and paid on December 1, 2015. This settlement resulted in a reduction to the projected benefit obligation of $129.3 million and a settlement loss of $36.8 million.

Aurora recognizes the funded status (that is, the difference between the fair value of the plan assets and the projected benefit obligation) of the Pension Plan in its consolidated balance sheet. The Pension Plan assets and obligations are measured as of December 31. Actuarial gains and losses that arise and are not recognized as net periodic pension cost in the same periods are recognized as a component of net assets. Aurora recognized pension (income) cost for the years ended December 31, 2016, 2015 and 2014 of $(0.6) million, $32.8 million (including the settlement loss), and $0.7 million, respectively.

The assumption for the expected return on the Pension Plan's assets is based on historical returns and adherence to the asset allocations set forth in the pension plan's investment policies. The expected return on the Pension Plan's assets for determining pension cost was 5.50% in 2016, 5.50% in 2015, and 6.25% in 2014. The discount rate used to measure the projected benefit obligation was 4.42%, 4.70%, and 4.32% as of December 31, 2016, 2015, and 2014, respectively.

The Pension Plan's assets are invested in a portfolio designed to preserve principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, while minimizing unnecessary investment risk. A summary of the Pension Plan's asset allocation targets by asset class and actual allocations by asset class at the measurement dates of December 31 was as follows:

	2016		2015		2014	
	Strategic Target	Actual	Strategic Target	Actual	Strategic Target	Actual
Equity securities	33%	33%	33%	32%	33%	36%
Fixed-income securities	64	62	64	65	64	60
Real estate	3	3	3	3	—	2
Cash and cash equivalents	—	2	—	—	3	2
Total	100%	100%	100%	100%	100%	100%

At the December 31, 2016 measurement date, the projected benefit obligation in excess of the fair value of plan assets for the Pension Plan was $117.0 million (92.1% funded) compared to $118.0 million (91.4% funded) at December 31, 2015. This decrease in the unfunded pension liability resulted from a $50.0 million contribution made to the Pension Plan. Offset by a decrease in the discount rate from 4.70% at December 31, 2015 to 4.42% at December 31, 2016 which resulted in an increase in Aurora's pension obligation of $56.3 million.

At the December 31, 2015 measurement date, the projected benefit obligation in excess of the fair value of plan assets for the Pension Plan was $118.0 million (91.4% funded) compared to $182.7 million (88.4% funded) at December 31, 2014. This decrease in unfunded pension liability resulted from an increase in the discount rate from 4.32% at December 31, 2014 to 4.70% at December 31, 2015, and the settlement of certain pension obligations in December 2015.

Pension-related changes other than net periodic pension costs decreased net assets by $49.7 million for the year ended December 31, 2016, increased net assets by $25.2 million for the year ended December 31, 2015 and decreased net assets by $113.7 million for the year ended December 31, 2014.

Aurora contributed $50.0 million, $72.3 million, and $43.9 million to the Pension Plan during the years ended December 31, 2016, 2015, and 2014, respectively. Aurora plans to continue to fund the Pension Plan to meet the minimum required funding levels.

The Corporation and certain affiliates sponsor defined contribution and retirement savings plans (the "Defined Contribution Plans"), whereby the Corporation contributes a percentage of participants' qualifying compensation up to certain limits as outlined in the Defined Contribution Plans or other amounts as designated by the affiliates' board of directors. During 2016, 2015, and 2014, included in salaries, wages and fringe benefits expense is $144.9 million, $136.9 million, and $128.5 million, respectively, for contributions to the Defined Contribution Plans.

The Corporation also sponsors a noncontributory Section 457(b) defined contribution plan (the "457(b) Plan") covering selected employees, where participants may contribute a percentage of qualifying compensation up to certain limits as defined by the 457(b) Plan. The 457(b) Plan assets and liabilities, totaling $102.6 million, $84.6 million, and $77.2 million December 31, 2016, 2015, and 2014, respectively, are included in long-term assets whose use is limited or restricted and pension and other employee benefit liabilities, in Aurora's consolidated financial statements. The assets of this 457(b) Plan are subject to the claims of the general creditors of Aurora.

Covenant Compliance

Aurora is subject to certain covenants in its Master Indenture and other agreements relating to its Indebtedness. These covenants include requirements relating to maintenance of property, continuation of operations, issuance of additional debt, and maintenance of certain financial ratios and indicators such as days' cash on hand, historical debt service coverage ratio, maximum annual debt service coverage ratio, and adjusted cash and investments to measured indebtedness. Aurora was in compliance with these covenants at December 31, 2016. The calculation relating to the financial covenant included in the Master Indenture, Historical Debt Service Coverage Ratio, is required to be calculated for Aurora on a consolidated basis, and is presented below:

Aurora Health Care, Inc. and Affiliates
Historical Debt Service Coverage Ratio
(dollars in thousands)

	December 31,		
	2016	**2015**	**2014**
Income Available for Debt Service:			
Excess of revenue over expenses	469,143	442,730	539,124
Depreciation and amortization	207,842	198,644	205,798
Interest expense	57,687	57,378	63,602
Total income available for debt service	734,672	698,752	808,524
Less Extraordinary or noncrecurring revenue and expense:			
Gain or loss resulting from either the early extinguishment or refinancing of Indebtedness	(2,070)	(543)	—
Gain or loss resulting from pension terminations, settlements or curtailments	—	(36,848)	—
Total extraordinary or nonrecurring revenue and expenses	(2,070)	(37,391)	—
Less unrealized gains or losses:			
Unrealized gains (losses) on investments	59,827	(44,170)	2,899
Less: asset impairment charges	—	(4,221)	(2,452)
Total adjustments	57,757	(85,782)	447
Income Available for Debt Service	$ 676,915	$ 784,534	$ 808,077
Debt Service Requirements:			
Interest payments due in current year	$ 59,636	$ 57,900	$ 64,154
Principal payments due in current year	69,841	58,061	54,633
Debt Service Requirements	$ 129,477	$ 115,961	$ 118,787
Historical Debt Service Coverage Ratio	5.23	6.77	6.80

Required covenant level is 1.1 for a consultant call in and 1.0 for an event of default.

Aurora Health Care, Inc. and Affiliates
Days' Cash on Hand
(dollars in thousands)

	December 31,		
	2016	**2015**	**2014**
Adjusted Cash and Investments			
Cash and cash equivalents	$ 107,664	$ 176,626	$ 238,772
Investments	1,614,843	1,272,107	1,157,604
Assets whose use is limited – current	5,484	10,793	5,560
Assets whose use is limited - non current	398,048	375,551	381,003
Less: Trustee held funds	(755)	(955)	(699)
Less: Donor restricted funds	(53,821)	(54,542)	(56,139)
Less: Other third-party restricted funds	(184,788)	(177,603)	(169,318)
Adjusted Cash and Investments	$ 1,886,675	$ 1,601,977	$ 1,556,783
Days of Operating Expenses			
Operating expenses	4,751,475	4,467,643	4,213,068
Plus: Provision for bad debts	140,151	132,805	56,402
Less: Depreciation and amortization	(207,842)	(198,644)	(205,798)
Adjusted Operating Expenses	$ 4,683,784	$ 4,401,804	$ 4,063,672

	December 31,		
	2016	**2015**	**2014**
Number of days in applicable testing period	366	365	365
Operating Expenses per Day	$ 12,797	$ 12,060	$ 11,133
Days' Cash on Hand	147	137	142

Required covenant level is 40 days for a consultant call in and 25 days for an event of default.

Critical Accounting Policies

Investments and Investment Income — Investments in equity securities with readily determinable fair values and all investments in debt securities are reported at fair value based upon quoted market prices in active markets or other observable inputs and are classified as trading securities. Investments in a real estate investment trust and an international equity limited partnership are reported at net asset value (NAV) reported by the fund, which approximates fair value. Certain investments considered available to support current operations are classified as current.

Investment income or loss on funds held for professional liability coverage and certain employee benefit investments is included in other operating revenue. All other investment income or loss (including realized gains and losses, unrealized gains and losses, interest income, and dividends) is included in nonoperating income (loss), net, unless the income or loss is restricted by donor or law.

Assets Whose Use Is Limited or Restricted — Assets whose use is limited or restricted include investments and other assets set aside by the board of directors at their discretion for future capital improvements or for other purposes, assets held in trust under bond indenture for debt service reserve funds, contractually restricted funds, and donor-restricted funds.

Patient Accounts Receivable — Patient accounts receivable are stated at net realizable value. Patient accounts receivable are reduced by an allowance for contractual adjustments and also by an allowance for doubtful accounts. In evaluating the collectability of patient accounts receivable, Aurora analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for contractual adjustments and allowance for doubtful accounts. Management regularly reviews data about these major payor sources in evaluating the sufficiency of the allowance for contractual adjustments and allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party coverage, Aurora analyzes contractually due amounts and provides an allowance for contractual adjustments, as well as an allowance for doubtful accounts, if necessary. For receivables associated with self-pay patients, Aurora records a significant provision for bad debts and charity care in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts in the period they are determined to be uncollectible.

Aurora does not maintain a material allowance for doubtful accounts for amount due from third-party payors and did not have significant write-offs from third-party payors.

Income Taxes — Aurora evaluates its uncertain tax positions on an annual basis. A tax benefit from an uncertain tax position may be recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits.

Deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the financial statement carrying amount of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are classified as non-current in the accompanying consolidated balance sheets.

Aurora assesses the realization of its deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, Aurora determines whether it is more likely than not that all or a portion of the deferred tax assets will be realized.

Patient Service Revenue (net of contractual allowances and discounts) — Patient service revenue is reported at the net realizable amounts from patients, third-party payors, and others for services rendered. Aurora has agreements with payors that provide for payments at amounts different from established rates. The basis for payment under these agreements includes prospectively determined rates, per diem payments, negotiated discounts from established charges, and retroactive settlements under reimbursement agreements with third-party payors.

Charity Care and Uninsured Care – Aurora provides care to patients who meet certain criteria under its Helping Hands program without charge. Because Aurora does not pursue collection of amounts determined to qualify as charity care under this program, they are not reported as revenue. Aurora also provides care to uninsured patients who do not meet the criteria of the Helping Hands program at amounts less than its established rates.

Provision for Bad Debts —Aurora recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy) at the time services are rendered, prior to assessing the patient's ability to pay. As such, the entire provision for bad debts is presented as a reduction from patient service revenue. On the basis of its historical experience, a significant portion of Aurora's uninsured patients will be unwilling or unable to pay for the services provided. In addition, a portion of Aurora's insured patients will be unwilling or unable to pay the portion of their bill for which they are financially responsible. Aurora records a provision for bad debts related to uninsured patients, and insured patients for the portion of their bill for which they are financially responsible in the period services were provided.

Bond Ratings

Aurora’s outstanding bonds have been assigned ratings of A+ (stable outlook) and A2 (stable outlook) by Fitch and Moody’s, respectively. Additional information on Aurora's bond rating can be obtained from Aurora's "Investor Relations" site found at https://www.aurorahealthcare.org/about-aurora/investor-relations-financial-information.

GOVERNANCE

Corporation

Board Structure. The Corporation is governed by a Board of Directors consisting of at least 3 but not more than 20 self-electing members (excluding the ex officio members) (the "Aurora Board"). Each director (excluding the ex officio members) holds office for a three-year term and may serve for no more than three successive full terms (other than the chairman who may serve one additional three-year term in certain circumstances).

Members and officers of the Aurora Board are:

Name	Business Affiliation	Member of Board Since	Current Term Expires
Joanne B. Bauer	Retired President Kimberly-Clark Health Care	2013	2019
Thomas Bolger	CEO Johnson Financial Group	2009	2018
John Daniels	Chairman Emeritus Quarles & Brady LLP	2008	2017
Stephen Dickson	Retired Vice President and Controller WEC Energy Group Inc.,	2015	2018
Joanne Disch, PhD, RN, FAAN	Chair Clinical Professor & Director Densford International Center for Nursing Leadership University of Minnesota School of Nursing	2008	2017
Dr. Tejal Gandhi	Chief Executive Officer National Patient Safety Foundation	2016	2019
Nan Gardetto	President and Founder The EveryDayGood Foundation	2010	2019
Charles Harvey	Retired Chief Diversity Officer Johnson Controls	2013	2019

Daniel Minahan	President & COO Continental Properties, Co., Inc.	2007	2019
Chris L. Shimojima	Founder, The Pocket Suite, LLC Former CEO, Provide Commerce Inc.	2015	2018
Tim Sullivan	CEO REV Group, Inc.	2010	2019
Nick Turkal, M.D.	President and CEO Aurora Health Care, Inc.	2006	Ex Officio
Rick Weiss	Retired Partner Foley & Lardner LLP	2010	2019
Chris White	Vice President - Safety and Security Air Wisconsin Airlines Corporation	2008	2017

Committee Structure. The bylaws of the Corporation provide for eight standing committees: the Executive Committee, the Compensation Committee, the Quality Committee, the Finance Committee, the Audit and Compliance Committee, the Investment Committee, the Governance Committee, and the Strategic Affairs Committee. The bylaws also permit the Chairman of the Aurora Board and the Board itself to create additional committees from time to time.

Executive Committee. The Executive Committee to the Aurora Board (the "Executive Committee") has at least three directors elected by the Board. The Executive Committee is authorized to exercise the powers of the Aurora Board when the Aurora Board is not in session.

Compensation Committee. The Compensation Committee consists of at least three independent members appointed from time to time by the Chairman of the Board. The Committee exercises the full authority of the Aurora Board to: (a) review and approve the compensation and benefits of the President/Chief Executive Officer and those executives reporting directly to him or her; (b) review and approve the aggregate compensation and benefits philosophy and plans for employees of Aurora; and (c) retain and meet with independent consultants, as appropriate, to assure that Aurora's compensation and benefit plans are reasonable, competitive and fiscally responsible.

Quality Committee. The Quality Committee is composed of at least seven members, as appointed by the Chairman of the Aurora Board from time to time. The Quality Committee is responsible for overseeing Aurora's clinical quality, safety, service and risk management matters.

Finance Committee. The Finance Committee consists of at least seven members appointed by the Chairman of the Aurora Board. The Finance Committee advises the Aurora Board on all matters relating

to financial affairs, including the review of operating and capital budgets, review and approve new debt obligations, the debt structure, and short-term and long-term financing plans; and review Aurora's current and projected financial performance.

Audit and Compliance Committee. The Audit and Compliance Committee consists of members who are independent of management and free of any relationship that, in the opinion of the Aurora Board, would interfere with their exercise of independent judgment as committee members. The Audit and Compliance Committee consists of members who have experience in the area of financial reporting, including at least one individual who is deemed an "expert" on accounting and financial reporting matters. The Audit and Compliance Committee is responsible for receiving reports, providing advice, making recommendations and providing assistance to Aurora's Board in overseeing Aurora's accounting and financial reporting practices, including communications with Aurora's independent auditors, internal audit, and compliance functions. The Audit and Compliance Committee is also responsible for reviewing actions taken to address IT cybersecurity risk.

Investment Committee. The Investment Committee consists of at least six members as are appointed from time to time by the Chairman of the Aurora Board. The Investment Committee is responsible for overseeing and monitoring Aurora's investments, and has responsibilities and authority to: (a) make recommendations on an annual basis to the Aurora Board regarding asset allocations; (b) determine which entities will be utilized for investment placement; (c) hire, retain and evaluate financial advisors as deemed necessary; (d) recommend investment policies for Aurora's investment portfolios to the Aurora Board; (e) oversee and monitor the investment of Aurora's investment portfolios; and (f) at least annually prepare a detailed review of investment performance and strategy for the Aurora Board.

Governance Committee. The Governance Committee is composed of at least three members, as appointed by the Chairman of the Aurora Board from time to time. The Governance Committee is responsible for providing assistance to the Aurora Board in corporate governance related matters, including, but not limited to: (a) develop, monitor and evaluate corporate governance principles, guidelines or policies; (b) nominate or recommend to the Aurora Board persons to be elected as Directors and officers for Aurora; (c) make recommendations to the Aurora Board regarding the qualifications of candidates for the Aurora Board and the director selection process; (d) consider amendments to the Corporation's Articles of Incorporation and Bylaws and the charter documents of its subsidiaries and make recommendations to the Aurora Board concerning such proposed amendments; (e) review and make recommendations to the Board regarding matters relating to the structure and operation of the Aurora Board; (f) oversee the evaluation of the Aurora Board and the self-assessment of Directors; and (g) assist management in evaluating potential candidates for key executive positions, including chief executive officer, and oversee development of executive succession plans.

Strategic Affairs Committee. The Strategic Affairs Committee is composed of five members. Members of the Strategic Affairs Committee are appointed by the Chairman of the Aurora Board, the majority of whom are current members of the Board. The Strategic Affairs Committee is responsible for reviewing and considering Aurora's key strategic initiatives including but not limited to involvement in the development of Aurora's long-term strategic plan, and evaluation of key strategic opportunities.

Transactions with Officers and Directors. Aurora has entered into transactions from time to time with business organizations with which one or more officers or directors of Aurora or Affiliates of Aurora are associated. Under existing policy, such transactions or affiliations are permitted only after compliance with the Corporation's conflict of interest policy which may include full discussion of the potential conflict of interest with the Aurora Board and approval by a majority of the disinterested members of Aurora Board. All such transactions to date have been in the ordinary course of Aurora's business. Richard Weiss, director of the Aurora Board, is a retired partner with the law firm of Foley & Lardner LLP, which serves as legal counsel to Aurora on various matters. In addition, John Daniels, a director of the Aurora Board, is Chairman Emeritus at the law firm of Quarles & Brady LLP, which serves as legal counsel to Aurora on human resource and other matters, and serves as bond counsel and general counsel to the Wisconsin Health and Educational Facilities Authority, which issues tax-exempt bonds on Aurora's behalf.

Board Compensation. Directors of the Aurora Board are compensated for their time spent attending and preparing for Aurora Board and committee meetings. Also, members of the Audit and Compliance Committee are compensated for their time spent attending and preparing for Audit and Compliance Committee meetings.

Affiliates

Each Aurora affiliate has a governing body. Certain powers with respect to governance and management, including the power to appoint and remove directors, are reserved through by-law provisions to the sole member of such affiliate or delegated to another affiliate. In the case of all first tier subsidiary affiliates and certain second tier subsidiary affiliates which are members of the Obligated Group, the Aurora Board must approve, among other things: (i) any change in mission or services of the affiliate; (ii) the incurrence of debt or the guarantee of debt by the affiliate; (iii) the sale or other disposition of any affiliated, controlled or joint venture entity or real or personal property or other assets of the affiliate; and (iv) the annual operating and capital expenditure budgets. Aurora, indirectly through its first tier subsidiary affiliates, in effect has the same governance control over lower tier subsidiary affiliates.

MANAGEMENT

List of Key Employees

A management team with significant healthcare experience and diverse backgrounds leads Aurora. Aurora's executive management team has extensive and diverse experience in the healthcare industry. Certain members of the Corporation's management team are currently on the board of other companies and healthcare organizations, which adds to their diverse experience, as well as depth and knowledge of the industry.

The following individuals represent the President and Executive Vice Presidents of Aurora:

Andy Anderson, MD, age 49, Chief Medical Officer: Dr. Andy Anderson joined Aurora Health Care in 2011 and was named chief medical officer in 2015. Dr. Anderson is responsible for Aurora's strategic direction and operational deployment of critical physician and clinical support functions, including clinical risk management, infection prevention, medical staff services and case management. Dr. Anderson also oversees ACL clinical labs and serves as executive leader of the Aurora Research Institute, champions Aurora's wellness programs, leads clinical informatics, and oversees medical education for the system. He previously served as senior vice president of academic affairs and co-led primary care, where he played a key role in shaping the future of primary care and care redesign at Aurora. Prior to joining Aurora Health Care, Dr. Anderson served in multiple leadership roles during more than 15 years of work at a variety of national health care systems, including Chicago-based NorthShore University HealthSystem, the University of Chicago Hospitals, and the Medical College of Wisconsin/Froedtert Health. Dr. Anderson continues to see patients in addition to his leadership responsibilities. He holds a bachelor's degree and medical degree from the University of North Carolina and a master's in business administration from Marquette University.

Jeffrey K. Bahr, MD, age 44, Executive Vice President, President of Aurora Health Care Medical Group: Dr. Jeff Bahr joined Aurora Health Care in 2002. As president of the Aurora Health Care Medical Group, Dr. Bahr is responsible for the strategy of the medical group practice and providing leadership to physicians across eastern Wisconsin. He is a practicing internist and previously served as vice president of the Primary Care Clinical Program within Aurora. In this role, Dr. Bahr co-led initiatives in growth, service quality, clinical quality, caregiver engagement and workforce planning. In addition to his departmental leadership role, Dr. Bahr served as medical director for medical group operations and practice optimization. Dr. Bahr became a member of Alpha Omega Alpha in 2001, and in 2012 was awarded fellowship status in the American College of Physicians. Dr. Bahr is board certified in internal medicine. He completed his residency in internal medicine at the Medical College of Wisconsin Affiliated Hospitals, where he also served as chief resident and was an instructor in the Department of Medicine. Dr. Bahr received his bachelor's degree from Marquette University and his medical degree from the Medical College of Wisconsin in Milwaukee.

Jeff Bard, age 49, Executive Vice President, North Region: Jeff Bard joined Aurora Health Care in 2007. As executive vice president for Aurora's North Region, he provides operational and strategic leadership for clinic, hospital and Aurora at Home operations serving Green Bay, Marinette, Manitowoc,

Oshkosh and Fond du Lac. He is responsible for driving clinical and service excellence, caregiver and physician engagement, strategic growth and financial performance. As president of Aurora's Oshkosh and Fond du Lac service market, he partners with local physician leadership to set strategic direction for 12 clinics and Aurora's Oshkosh hospital. He also oversees Food and Environmental Services. Jeff previously was director of clinic operations at ProHealth Care, overseeing daily operations for over 100 primary and specialty care physicians. Outside of Aurora, Jeff is member of the Health Management Academy's Regional/Hospital Chief Executive Officer Forum and the academy's Administrative Fellowship Program. He is a board member of the Oshkosh Chamber of Commerce and the YMCA of Oshkosh. Jeff earned two master's degrees at the University of Minnesota.

Michael Brophy, age 58, Chief of Staff and Chief Communications Officer: Michael Brophy rejoined Aurora Health Care in 2009. He serves as chief of staff to Aurora CEO Nick Turkal, MD, and as the system's chief communications officer. In these roles, Mike is responsible for reputation management and media relations, consumer engagement and marketing, executive communications and employee communications. In addition, he leads strategic planning and helps to manage the Office of the CEO, including internal and external communications for the CEO. Mike previously served as vice president of communications and primary spokesperson for Milwaukee-based Midwest Airlines, where he managed media relations, employee communications, government affairs and community outreach. He was director of corporate communications and director of public affairs for Miller Brewing Company for over a decade. Mike was also director of communications for two regions of Aurora Health Care, and has worked in several advertising agencies and public relations firms, state government and as a political campaign consultant. Outside of Aurora, Mike is vice chair of the Penfield Children's Center Board of Directors, and a member of the Board of Visitors for the University of Wisconsin-Madison School of Journalism and Mass Communications. He earned a bachelor's degree from the University of Wisconsin-Madison.

Gerard Colman, PhD, age 46, Chief Operating Officer: Gerard Colman, PhD, joined Aurora Health Care in 2014. As chief operating officer, he oversees hospital, clinic and home care operations. He has more than 25 years of health care management and finance experience. Prior to joining Aurora, Gerard was senior vice president and chief of clinical operations at the University of Texas MD Anderson Cancer Center in Houston, where he was responsible for hospital and clinic operations, ancillary services, and several off-campus care operations. He was responsible for the strategic revenue and annual budget process for a $4 billion-plus operating margin and the coordination of research funding as it related to hospital operations. Prior to joining MD Anderson in 2004, Gerard was administrative director of patient care operations and financial services for Newark Beth Israel Medical Center, Irvington General Hospital and the Children's Hospital of New Jersey. Gerard began his career in health care in the United States Navy. He is a board member of the Wisconsin Hospital Association, a fellow of the American College of Health Care Executives and the Health Care Financial Management Association, and a member of the Health Management Academy and the Leadership Institute. Gerard received his bachelor's degree from Southern Illinois University, a master's degree from the School of Social Research in New York, and a PhD from the University of Texas School of Public Health.

Patrick Falvey, PhD, age 52, Chief Transformation Officer: Patrick Falvey, PhD, joined Aurora Health Care in 1992, and has served in multiple leadership roles overseeing productivity, operations, quality, care

management, strategy and research. As chief transformation officer, he leads strategies designed to enable Aurora to evolve to better meet both local and national market changes. Patrick's key Aurora accomplishments include having Aurora receive top honors in CMS' Hospital Quality Incentive demonstration and QUEST for consecutive years, moving all Aurora medical centers to top-quartile performance in productivity results, redesigning the clinical research departments, and having all five hospitals under his responsibility achieve financial, productivity and quality targets with improvement in service measures. Outside of Aurora, Patrick is on the board of the Wisconsin Collaborative for Healthcare Quality (finance chair), the Children's Community Center (past president and current finance chair), and is a member of the AboutHealth Quality Committee. He holds a bachelor's degree from the University of Wisconsin-Whitewater, a master's degree from the University of Wisconsin-Oshkosh, and a doctorate from the University of Wisconsin-Milwaukee.

Cristy Garcia-Thomas, age 48, Chief Diversity and Inclusion Officer, President of Aurora Health Care Foundation: Cristy Garcia-Thomas joined Aurora Health Care in 2011. As chief diversity and inclusion officer, she leads system initiatives which incorporate diversity and inclusion into Aurora's culture, from patient care and experience, caregiver recruitment and engagement, retention and organizational development to supplier diversity, marketing, community relations and service quality programs. As president of the Aurora Health Care Foundation, Cristy oversees funds raised and invested for all Aurora hospitals, Aurora Family Service, Aurora clinics, the Aurora Research Institute, The Healing Center and Aurora at Home. She also has responsibility for the strategy of Aurora's social responsibility and community benefits programs. Prior to joining Aurora, Cristy served as the president of the United Performing Arts Fund (UPAF) and was publisher and vice president of the Specialty Media Division of the Milwaukee Journal Sentinel and worked for The Wichita (Kan.) Eagle. Cristy currently serves on the board of directors for PAVE, the United Community Center and the Wisconsin Club. She is a member of the Greater Milwaukee Committee, the United Way of Greater Milwaukee Women's Leadership Council, the National Forum for Latino Healthcare Executives and TEMPO Milwaukee. Cristy has served on the boards of Aurora Health Care and Girl Scouts and is a past board chair of TEMPO Milwaukee. She has received the Hispanic Chamber of Commerce of Wisconsin Latina of the year Award in 2014, The Business Journal's Women of Influence Award in 2013, The Business Journal's "40 under 40" award, the Hispanic Professionals of Greater Milwaukee Executive of the Year, the United States Post Office Women Putting a Stamp on Milwaukee Award, and the Milwaukee Business Journal's Power List in Arts. Cristy holds a bachelor's degree from Kansas State University and has completed executive-level programs at Northwestern University and Harvard Business School.

Michael Grebe, age 50, Chief Legal Officer: Michael Grebe joined Aurora Health Care in 2017. As chief legal officer, he is responsible for overseeing all legal affairs for Aurora, with a particular focus on corporate and transactional matters. Michael has had extensive experience as a leader in the business and legal community during his nearly 25-year career. Prior to joining Aurora, Michael was executive vice president and general counsel to HUSCO International, Inc., and was previously a partner at the law firm of Quarles & Brady. He is a member of the University of Wisconsin Board of Regents and is a former board chair of the Columbia St. Mary's Foundation. Grebe earned his bachelor's degree from Dartmouth College and his law degree from the University of Wisconsin.

Gail L. Hanson, age 61, Chief Financial Officer: Gail Hanson joined Aurora Health Care in 2011. As chief financial officer, she is responsible for capital and operating budgets, accounting, affiliation due diligence, the business office, and finance and treasury services. She oversees external audit and preparation of annual financial reports. Prior to joining Aurora, Gail served as deputy executive director for the State of Wisconsin Investment Board for six years, overseeing all operational aspects, including accounting, governance and general management functions. She also was treasurer and chief financial officer of Cobalt Corporation and held positions of increasing responsibility at Blue Cross Blue Shield United of Wisconsin. She is a board member of the Kern Family Foundation and the State of Wisconsin Deferred Compensation Board, as well as a board member and audit committee chair for Artisan Funds and Northwestern Mutual Series Funds. Additionally, she serves on the board of Milwaukee Women inc (MWi). Gail is a certified public accountant and chartered financial analyst and holds a bachelor's degree from the University of Michigan and a master's degree from the University of Chicago.

Shelly Hart, age 53, Senior Vice President and General Counsel: Shelly Hart joined Aurora Health Care in 2010 as deputy general counsel and became general counsel in 2013. In this role, she is responsible for overseeing all health care related aspects of the legal department, with a particular focus on regulatory and provider matters. Prior to joining Aurora, Shelly was a partner in the Milwaukee office of Foley & Lardner, LLP, where her practice involved the representation of health systems, hospitals, medical clinics, physicians, nursing homes and other health care providers for more than 20 years. Shelly serves on the board of directors of the Jewish Home and Care Center, the Jewish Home and Care Center Foundation, and the Aurora Health Care Foundation. She has received numerous professional and civic awards including recognized among Women in the Law in 2014 by the Wisconsin Law Journal. Shelly received her bachelor's degree from the University of Wisconsin-Madison and her law degree from the University of Wisconsin Law School.

Carrie Killoran, age 44, Executive Vice President, Central Region: Carrie Killoran joined Aurora Health Care in 2009. As executive vice president for Aurora's Central Region, Carrie provides operational and strategic leadership for clinic, hospital and Aurora at Home operations for a geographic area ranging from north of Milwaukee to Sheboygan as well as Waukesha and Jefferson counties. She is responsible for driving clinical and service excellence, caregiver and physician engagement, strategic growth and financial performance. Prior to her current role, Carrie was president of Aurora's Greater Milwaukee North/Sheboygan Patient Service Market. She also served as senior vice president and chief compliance/ integrity officer, overseeing Aurora's compliance and audit programs and policies. Before joining Aurora, Carrie was a partner at two Milwaukee law firms, Quarles & Brady LLP and Michael Best & Friedrich LLP, as well as vice president and associate general counsel for Wheaton Franciscan Healthcare. Outside of Aurora, Carrie holds numerous professional memberships, including the American College of Healthcare Executives, Health Care Compliance Association and American Health Lawyers Association. She also received "40 Under 40" award recognition from the Milwaukee Business Journal. Carrie received her bachelor's degree from Macalester College and a law degree and master's degree from Harvard University.

Mary Beth Kingston, age 61, Chief Nursing Officer: Mary Beth Kingston, RN, joined Aurora Health Care in 2012. As executive vice president and chief nursing officer, she co-leads the strategy for integrated services, and provides strategic direction for nursing, clinical education and chief nurse

executives. In partnership with the chief medical officer and chief integration officer, she is responsible for clinical transformation, patient care service enhancement and clinical quality and safety improvement. Mary Beth is also responsible for developing and mentoring nursing leadership, as well as advancing the professional practice of nursing and leading system nursing shared governance. Prior to joining Aurora, Mary Beth was vice president and chief nurse executive at Einstein Healthcare Network in Philadelphia. During her 35-year career, Mary Beth served in a variety of other nursing and administrative roles, including chief nursing officer at Graduate Hospital in Philadelphia; president of Bates and Associates, a health care consulting firm; vice president of operations and chief nursing officer at Delaware County Memorial Hospital in the Crozer Keystone Health System; and associate director of emergency services at the Hospital of the University of Pennsylvania. Outside of Aurora, Mary Beth serves on the boards of the Milwaukee Urban League, and Mount Mary University, both in Milwaukee. She was a Robert Wood Johnson Executive Nurse Fellow from 2009-2012 and a 2007 recipient of the Pennsylvania Nightingale Award for Nursing Administration. Mary Beth was elected to the board of the American Organization of Nurse Executives in 2014. She earned a bachelor's degree at West Chester University, a master's degree at the University of Pennsylvania, and is currently pursuing her PhD.

Rick Klein, age 59, Chief of Business Strategy and Payor Relations: Rick Klein joined Aurora Health Care in 1986. As chief of business strategy and payor relations, he is responsible for Aurora's strategic business plan, as well as oversight of relationships with insurers and other payors. Rick was instrumental in the creation of the AboutHealth network, the eight-member statewide health care collaboration in Wisconsin designed to enhance clinical quality, increase efficiency and improve customer experiences through shared practices. Currently, Rick serves as an AboutHealth board member. Previously, Rick has served Aurora as executive vice president, Enterprise Business Group; senior vice president and vice president of business development; as well as vice president of marketing. Prior to joining Aurora, Rick was the assistant vice president of marketing for the former Firstar Corp., Wisconsin's largest bank. He is on the leadership council of United Way of Greater Milwaukee and Waukesha County and is a past board member of the Georgetown Scholarship Society. Rick holds a bachelor's degree from Georgetown University and a master's degree from Northwestern University's Kellogg School of Management.

Mike Lappin, age 52, Chief Administrative Officer, Corporate Secretary: Mike Lappin joined Aurora Health Care in 2009 as its first general counsel and was responsible for establishing Aurora's in-house legal department. As chief administrative officer, Mike is responsible for overseeing compliance, government relations, human resources, information services, internal audit, legal services, real estate and facilities management, as well as affiliations, acquisitions, joint ventures and other transactions. Mike serves as Aurora's corporate secretary. Prior to joining Aurora, Mike practiced law for more than 16 years at Quarles & Brady, a broad-based business firm which had six offices and approximately 450 lawyers across the country. His practice focused on representing clients in acquiring and selling businesses, negotiating commercial contracts and providing general business advice. Mike has served on the board of directors of numerous organizations, including the Wisconsin Health Insurance Risk Sharing Plan, Juvenile Diabetes Research Foundation, Milwaukee Jewish Federation, Jewish Family Services, Visiting Nurse Association, the United Way of Greater Milwaukee, Boys & Girls Club, the Mequon-Thiensville Education Foundation and the Mequon-Thiensville Basketball Association. Mike received bachelor's degree from Duke University and a law degree and master's degree from the University of Wisconsin.

Nan Nelson, age 53, Executive Vice President, Finance: Nan Nelson has been with Aurora Health Care since 2013. As executive vice president, finance, she has oversight of system financial planning and accounting. She previously served as senior vice president of finance for Aurora's Greater Milwaukee South region, where she also oversaw system operating and capital budgets as well as integrating functions. Prior to joining Aurora, Nan was chief financial officer for ProHealthCare. She is a certified public accountant, a member of the Healthcare Financial Management Association, and earned a bachelor's degree from the University of Wisconsin-Whitewater.

Dennis Potts, age 62, Executive Vice President, South Region: Dennis Potts joined Aurora Health Care in 1979. As one of two regional executive vice presidents, he provides operational and strategic leadership for key clinical programs and operations for Aurora's South Region, which includes Aurora St. Luke's Medical Center - Aurora's flagship quaternary medical center - and other hospitals and clinics between Milwaukee and northern Illinois. Dennis has overall responsibility for clinic and hospital operations in the South Region. He is responsible for increasing service and clinical quality outcomes, fostering collaboration and integration, and managing profit and loss margins. In addition, Dennis establishes strategies to drive growth and employee engagement. He also oversees Aurora at Home and facilities. Prior to his current role, Dennis served as executive vice president and president for Aurora St. Luke's Medical Center. Dennis serves on the board of the Wisconsin Donor Network. He holds a bachelor's degree from Cardinal Stritch University and a master's degree from the University of Wisconsin-Milwaukee.

Amy Rislov, age 47, Chief Human Resources Officer: Amy Rislov joined Aurora Health Care in 1997. As chief human resources officer, she is responsible for all aspects of human resources and loss prevention for the system. Amy enables a high performance culture by delivering talent strategies to meet the organization's priorities, including efforts around diversity and inclusion, as well as learning and development. Outside of Aurora, Amy is a member of the Society of Human Resource Management, the American Society for Healthcare Human Resources Administration, TEMPO Milwaukee (past president), the Academy CHRO Forum, and is a founding member of the Center for Health Care Careers of Southeastern Wisconsin. She is a board member of Meta House and a former board member of United Way Waukesha County, the Arthritis Foundation of Wisconsin, and the Waukesha County Economic Development Corporation. Amy received her bachelor's degree from the University of Wisconsin-Madison and her master's degree from Cardinal Stritch University.

Preston Simons, age 58, Chief Information Officer: Preston Simons joined Aurora Health Care in 2015. As chief information officer, Preston leads Aurora's effort to use technology and innovative IT tools and services to help deliver a person-focused, best-in-class integrated health care experience. He is responsible for IT opportunity discovery, information strategy, applications development, infrastructure, business operations, cybersecurity, customer support, and IT investment portfolio management. Prior to joining Aurora, Preston was CIO of Abbott Laboratories, a Fortune 100 medical device and life sciences company. He previously served as the IT leader in several health systems, a health insurance plan and in the pharmaceutical industry. He also had significant responsibilities for operating the IT and infrastructure of AbbVie, which was spun off from Abbott Laboratories in 2013. Preston is a member of the Managed Care Executive Group, Healthcare Information Management Systems Society of the American Hospital Association, and the Society for Information Management. Additionally, he has had a leading role in the

Chicago CIO Institute. Preston holds a bachelor's degree from the Illinois Institute of Technology and a master's degree from the Booth School of Business at the University of Chicago.

Nick W. Turkal, MD, age 61, President and Chief Executive Officer: Dr. Nick Turkal joined Aurora in 1990 and was named president and chief executive officer in 2006. During the course of his career, he has cared for patients in rural private practice while holding a variety of leadership positions with Aurora. In addition to leading Aurora, Dr. Turkal continues to be board certified in family practice, holds memberships in a number of professional organizations and sees patients on a regular basis. Dr. Turkal is a member of the Creighton University Board of Trustees; the board of AboutHealth, a Wisconsin network of integrated health care systems; the board of StartUp Health, a health care transformation company; and the American Hospital Association Governing Council for Health Care Systems. He is a past chair of the Wisconsin Hospital Association Board of Directors. He has also served on the board of Premier and the Greater Milwaukee Committee, a coalition of businesses based in Milwaukee. Dr. Turkal received his bachelor's degree from Creighton University and his medical degree from the Creighton University School of Medicine.

RISK FACTORS

Our business is subject to a number of risks and uncertainties - many of which are beyond our control - that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in this report were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with emma.msrb.org, and our business, financial condition, results of operations or liquidity could be materially adversely affected.

We cannot predict the timing or outcome of any modification or repeal of the Affordable Care Act or what additional action, if any, legislators may take to replace the law, nor are we able to predict the ultimate effect that such actions may have on our business, financial condition, results of operations or cash flows.

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as result, our revenues has historically been derived from government healthcare programs, reductions to our reimbursement under the Medicare and Medicaid programs as a result of the ACA have been partially offset by increased revenues from providing care to previously uninsured individuals.

On January 20, 2017, the President issued an executive order declaring that the official policy of his administration will be to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations.

The U.S. Congress is currently exploring possible reforms to the nation’s health care system including changes to the ACA. Because the exact nature of any possible legislative and regulatory reforms at the federal level are unknown at this time we are unable to predict the impact of these potential legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in federal fiscal year ("FFY") 2018) are made.

If we are unable to enter into and maintain managed care contractual arrangements on acceptable terms, if we experience material reductions in the contracted rates we receive from managed care payers or if we have difficulty collecting from managed care payers, our results of operations could be adversely affected.

We currently have multiple managed care contracts with various HMOs and PPOs. The amount of our managed care net patient revenues during the year ended December 31, 2016 was $2.7 billion, which represented approximately 56% of our total patient service revenue. Approximately 86% of our managed care patient service revenue for the year ended December 31, 2016 was derived from our top five managed care payers. Our ability to maintain favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals and clinics. Furthermore, we may experience a short- or long-term adverse effect on our net operating revenue if we cannot replace or otherwise mitigate the impact of expired contracts with national payers.

In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. The trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on competitive terms. Any material reductions in the contracted rates we receive for our services or any significant difficulties in collecting receivables from managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from private payers could be exacerbated if we are not able to manage our operating costs effectively.

Further changes in the Medicare and Medicaid programs or other government healthcare programs, including reductions in scale and scope, could have an adverse effect on our business.

For the year ended December 31, 2016, approximately 26% of our patient service revenue was related to the Medicare program, and approximately 8% of our patient service revenue was related to the State of Wisconsin Medicaid program, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from government programs could be exacerbated if we are not able to manage our operating costs effectively.

The State of Wisconsin faces budgetary challenges that have resulted, and likely will continue to result in more stringent Medicaid eligibility requirements. The state is already in the process of seeking authorization from CMS to require able-bodied adults without children to pay premiums and enroll in job training. The state remains committed to fully funding the Medicaid program. As part of his 2017-19 budget recommendations, the Governor proposes fully funding the Medicaid Program. The budget recommendation includes reauthorization of the Disproportionate Share Hospital Program, which

provides supplemental payments to hospitals that have higher percentages of Medicaid patients, such as Aurora St. Luke's and Aurora Sinai Medical Centers.

In general, we are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or eligibility requirements lead to disenrollment and result in more uninsured patients, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

The industry trend toward value-based purchasing and alternative payment models may negatively impact our revenue.

Value-based purchasing and alternative payment model initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities, and may negatively impact our revenue if we are unable to meet expected quality standards. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions ("HACs"), unless the conditions were present at admission. Beginning in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year receive reduced Medicare reimbursements. Moreover, the ACA prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

The ACA also created the CMS Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries. In 2015, the Secretary of HHS announced a goal of tying 30% of traditional Medicare payments to quality or value through alternative payment models or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the mandatory bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria. In 2015, CMS finalized a five-year bundled payment model, called the Comprehensive Care for Joint Replacement ("CJR") model, which includes hip and knee replacements, as well as other major leg procedures. In 2016, CMS finalized additional mandatory bundled payment models, which are scheduled to begin on October 1, 2017, for Acute Myocardial Infarction ("AMI"), Coronary Artery Bypass Graft ("CABG") and Surgical Hip/Femur Fracture

Treatment ("SHFFT"). We cannot predict what effect significant modification or repeal of the ACA would have on the established payment models or the Secretary of HHS' authority to develop new payment models, nor can we predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenue or cash flows.

There is also a trend among private payers toward value-based purchasing and alternative payment models for healthcare services. Many large commercial payers expect hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts.

We are unable at this time to predict how the industry trend toward value-based purchasing and alternative payment models will affect our results of operations, but these could negatively impact our revenues, particularly if we are unable to meet the quality and cost standards established by both governmental and private payers.

Our hospitals, outpatient centers and other healthcare businesses operate in competitive environments, and competition in our service areas can adversely affect patient volumes.

The healthcare business is highly competitive, and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities (1) are more established or newer than ours, (2) may offer a broader array of services to patients and physicians than ours, and (3) may have larger or more specialized medical staffs to admit and refer patients, among other things. Furthermore, healthcare consumers are now able to access hospital performance data on quality measures and patient satisfaction, as well as standard charges for services, to compare competing providers; if any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or patient satisfaction surveys, or if our standard charges are higher than our competitors, we may attract fewer patients. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies, as well as health insurers and private equity companies seeking to acquire providers, in our service areas. We also face competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high margin services and for quality physicians and personnel. In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic imaging centers in the geographic areas in which we operate has increased significantly. If our competitors are better able to attract patients, recruit physicians and specialized staff, expand services or obtain favorable managed care contracts at their facilities than we are, we may experience an overall decline in patient volumes.

Our business and financial results could be harmed if we are alleged to have violated existing regulations or if we fail to comply with new or changed regulations.

Our hospitals, outpatient centers and related healthcare businesses are subject to extensive federal, state and local regulation relating to, among other things, licensure, contractual arrangements, conduct of operations, privacy of patient information, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the healthcare industry are extremely complex and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. Moreover, under the ACA, the government and its contractors may suspend Medicare and Medicaid payments to providers of services "pending an investigation of a credible allegation of fraud." The potential consequences for violating such laws, rules or regulations may impact reimbursement of government program payments and/or lead to the assessment of civil monetary penalties, including treble damages, fines, which could be significant, exclusion from participation in federal healthcare programs, or criminal sanctions against current or former employees, any of which could have a material adverse effect on our business, financial condition or cash flows. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on our business reputation.

Furthermore, healthcare, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local healthcare regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively affecting healthcare providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We are also required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

We could be subject to substantial uninsured liabilities or increased insurance costs as a result of significant legal actions.

We are subject to medical malpractice lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. Our professional and general liability insurance does not cover all claims against us, and it may not continue to be available at a reasonable cost for us to maintain at adequate levels, as the healthcare industry has seen significant increases in the cost of such insurance due to increased litigation. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians.

The success of our business depends in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and who affiliate with us and use our facilities as an extension of their practices. Members of the medical staffs of our hospitals also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing facilities at any time.

We may encounter increased competition from health insurers and private equity companies seeking to acquire providers our service areas. In some of our service areas, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Furthermore, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Physician Self-Referral (Stark) law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. Underlying these rules and regulations is the requirement that all arrangements with physicians must be fair market value and commercially reasonable. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

Our labor costs could be adversely affected by competition for staffing, and shortages of experienced talent.

The operations of our facilities are dependent on having the right number of qualified employees, including leaders, nurses, therapists, pharmacists and technicians, as well as our employed physicians. We compete with other healthcare providers in recruiting and retaining employees, and, like others in the healthcare industry, we experience shortages of specially trained employees in certain disciplines and geographic areas over time. As a result, from time to time, we may be required to enhance wages, benefits and other programs to recruit and retain experienced employees, make greater investments in education and training for new graduates, or use overtime and hire more expensive temporary or contract employees to fill gaps in staffing. In general, our failure to recruit and retain qualified employees, or to control labor costs, could have a material adverse effect on execution of our strategy, financial condition, results of operations or cash flows. Additionally, the healthcare industry is a ripe target for union organizing efforts, and should such organizing efforts be successful, collective bargaining agreements have the potential to adversely affect labor costs.

Our business and financial results could be harmed by a national or localized outbreak of a highly contagious or epidemic disease.

If an outbreak of an infectious disease were to occur in our service area, our business and financial results could be adversely affected. The treatment of a highly contagious disease at one of our facilities may result in a temporary shutdown or diversion of patients. In addition, unaffected individuals may decide to defer elective procedures or otherwise avoid medical treatment, resulting in reduced patient volumes and operating revenues. Furthermore, we cannot predict the costs associated with the potential treatment of an infectious disease outbreak by our hospitals or preparation for such treatment.

Our business could be negatively affected by security threats, catastrophic events and other disruptions affecting our information technology and related systems.

As a provider of healthcare services, information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive and confidential data, including protected health information, personally identifiable information, and our proprietary and confidential business performance data. We utilize electronic health records and other health information technology, along with additional technology systems, in connection with our operations, including for, among other things, billing and supply chain and labor management. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the security and availability of the data we process, transmit and store, our information technology and infrastructure have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. While we are not aware of having experienced a material breach of cybersecurity, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we may be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, or invest in new technology designed to mitigate security risks. Third parties to whom we outsource certain of our functions, or with whom our systems interface, are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting one of our third-party service providers or partners could harm our business even if we do not control the service that is attacked. Further, successful cyber-attacks at other healthcare services companies, whether or not we are impacted, could lead to a general loss of customer confidence in our industry that could negatively affect us, including harming the market perception of the effectiveness of our security measures or of the healthcare industry in general, which could result in reduced use of our services. Though we have insurance against some cyber-risks and attacks, it may not be sufficient to offset the impact of a material loss event.

Furthermore, our networks and technology systems are subject to disruption due to events such as a major fires, telecommunications failure, terrorist attack or other catastrophic event. Any such breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact our ability to conduct normal business operations (including the collection of revenues), and could result in potential liability under privacy, security, consumer protection or other applicable laws, regulatory penalties, negative publicity and damage to our

reputation, any of which could have a material adverse effect on our business, financial position, results of operations or cash flows.

We cannot provide any assurances that our corporate development activities will achieve their business goals or the cost and service synergies we expect.

As part of our business strategy, we routinely review and analyze opportunities for acquisitions, divestitures, joint ventures and strategic alliances. We cannot provide any assurances that any transactions undertaken will achieve their business goals or the cost and service synergies we expect. In addition, our corporate development activities may present financial and operational risks, including diversion of management attention from existing core businesses and the integration or separation of personnel and financial and other systems. Future acquisitions could also result in the incurrence of additional debt, contingent liabilities and amortization expenses related to certain intangible assets, and increased operating expenses, any of which could adversely affect our results of operations and financial condition.

Economic factors have affected, and may continue to impact, our business, financial condition and results of operations.

We believe broad economic factors - including high unemployment rates in some of our service areas and instability in consumer spending - have affected our volumes and our ability to collect outstanding receivables. The United States economy remains unpredictable. If industry trends (including reductions in commercial managed care enrollment and patient decisions to postpone or cancel elective and non-emergency healthcare procedures) or general economic conditions worsen, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Furthermore, the availability of liquidity and credit to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, to access those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions, and our ability to refinance existing debt. An economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under our credit facilities, causing them to fail to meet their obligations to us.

Trends affecting our actual or anticipated results may require us to record charges that would negatively impact our results of operations.

As a result of factors that have negatively affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospitals' most recent projections. If these projections are not met, or negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges. Future restructuring of our operating structure that changes our goodwill reporting

units could also result in future impairments of our goodwill. Any such charges could negatively impact our results of operations.

Our level of indebtedness could, among other things, adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, and prevent us from meeting our obligations under the agreements relating to our indebtedness.

At December 31, 2016, we had approximately $1.6 billion of total long-term debt, as well as approximately $460.6 million in letters of credit outstanding in the aggregate and a $60.0 million line of credit outstanding, of which $38.8 million is outstanding. Our debt is secured on a parity basis by a Master Trust Indenture, which is collateralized by, among other things, our accounts (including accounts receivable) and a mortgage on our flagship hospital, Aurora St. Luke's Medical Center. From time to time, we expect to engage in additional capital market, bank credit and other financing activities, depending on our needs and financing alternatives available at that time.

The interest expense associated with our indebtedness offsets a substantial portion of our operating income. During 2016, our interest expense was $57.7 million and represented approximately 16% of our $373.3 million of operating income. As a result, relatively small percentage changes in our operating income can result in a relatively large percentage change in our net income, both positively and negatively. In addition:

- Our indebtedness may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt.

- We may be more vulnerable in the event of a deterioration in our business, in the healthcare industry or in the economy generally, or if federal or state governments substantially limit or reduce reimbursement under the Medicare or Medicaid programs.

- Our debt service obligations reduce the amount of funds available for our operations, capital expenditures and corporate development activities, and may make it more difficult for us to satisfy our financial obligations.

- Our indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.

- Some of our borrowings accrue interest at variable rates, exposing us to the risk of increased interest rates.

Furthermore, the Master Trust Indenture and the bank agreements that govern our outstanding debt contains, and any future debt obligations may contain, covenants that, among other things, restrict our ability to incur additional debt and sell assets.

We may not be able to generate sufficient cash to service all of our indebtedness, and we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our indebtedness depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to financial, business and other factors beyond our control. We cannot assure you that we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, including those required for operating our existing hospitals, for integrating our historical acquisitions or for future corporate development activities. We also may be forced to sell assets or operations, seek additional capital, or restructure or refinance our indebtedness. We cannot assure you that we would be able to take any of these actions, that these actions would be successful and permit us to meet our scheduled debt service obligations, or that these actions would be permitted under the terms of our existing or future debt agreements, including our Credit Agreement.

Restrictive covenants in the agreements governing our indebtedness may adversely affect us.

Our Master Trust Indenture and bank agreements governing our outstanding debt contain various covenants that, among other things, limit our ability and the ability of our subsidiaries to:

- incur, assume or guarantee additional indebtedness;
- incur liens;
- make certain investments;
- provide subsidiary guarantees;
- consummate asset sales;
- enter into sale and lease-back transactions;
- enter into transactions with affiliates; and
- consolidate, merge or sell all or substantially all of our assets.

These restrictions are subject to a number of important exceptions and qualifications.

In addition, the terms of our Master Trust Indenture and bank agreements require us to maintain certain financial ratios. Our ability to meet these restrictive covenants and financial ratio may be affected by events beyond our control, and we cannot assure you that we will meet those tests. These restrictions could limit our ability to obtain future financing, make acquisitions or needed capital expenditures, withstand economic downturns in our business or the economy in general, conduct operations or otherwise take advantage of business opportunities that may arise. In addition, a breach of any of these covenants could cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

Despite current indebtedness levels, we may be able to incur substantially more debt. This could further exacerbate the risks described above.

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our Master Trust Indenture and bank agreements (if applicable). We may decide to incur additional secured or unsecured debt in the future to finance our operations and any judgments or settlements or for other business purposes.

Proposed Changes to Tax Treatment of Tax-Exempt Bonds may limit our access to capital, increase our borrowing costs, and result in an increase in the interest rate on our variable rate debt.

Proposals to alter or eliminate the exclusion of interest on tax-exempt bonds from gross income for some or all taxpayers have been made in the past and may be made again in the future. Such legislative proposals, if enacted, could tax all or a portion of the interest on tax exempt bonds for certain taxpayers under the regular income tax, the alternative minimum tax or otherwise, and could apply to bonds issued before, on, or after the date of enactment.

It is unclear whether any legislation will be proposed or enacted affecting the tax treatment of interest on tax-exempt bonds issued for the benefit of Aurora. If any such legislation is retroactive and applies to tax-exempt bonds previously issued for the benefit of an Aurora System Entity, the adoption of any such legislation could adversely affect the financial condition of Aurora. In addition, the adoption of any such legislation could increase the cost to Aurora of financing future capital needs.

Proposed changes to the Federal Income Tax rates may limit our access to capital, increase our borrowing costs, and result in an increase in the interest rate on our variable rate debt.

The President and Republican members of Congress have indicated their intent to significantly modify the Federal income tax system. To the extent that any such modification includes a reduction of Federal income tax rates, the value of the Federal tax exemption of our debt would likely weaken, resulting in, among other things, increased borrowing costs and increased interest rates on our variable rate debt.

Loss of Real Property Tax Exemptions would adversely affect us.

Real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities have been challenged on the grounds that the health care providers were not engaged in sufficient charitable activities. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins.

In July 2011, the Wisconsin Supreme Court affirmed that off-campus hospital outpatient facilities qualify for Wisconsin property tax exemption. Specifically, the Supreme Court held that a hospital outpatient facility operated by Wheaton Franciscan Healthcare in Wauwatosa, Wisconsin is exempt from the property tax under the same statute that exempts hospitals. Although this decision will allow Wisconsin hospitals to maintain property tax exemption for off-campus facilities that provide hospital-based outpatient services, there can be no assurance that future disputes challenging property tax exemption of other health care facilities will not arise within the State.

Loss of nonprofit status would have a materially adverse effect on our operations.

As nonprofit tax-exempt organizations, certain Aurora affiliates are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organization and operation, including their operation for charitable purposes. At the same time, Aurora conducts large-scale complex business transactions and is a major employer in its geographic areas. 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 health care organization.

Recently, an increasing number of the operations or practices of health care providers have been challenged or questioned to determine if they are in compliance with the regulatory requirements for nonprofit tax-exempt organizations. These challenges, in some cases, are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the health care organizations. Areas that have come under examination have included pricing practices, billing and collection practices, charitable care, executive compensation, exemption of property from real property taxation and others.

A loss of our nonprofit status would result in a significant increase in operating costs, including, among other things, the payment of Federal and State income tax, loss of property tax exemption, limitation on the ability to fundraise and increased borrowing costs.