Aurora Health Care®

Aurora Health Care, Inc. and Affiliates

Unaudited Consolidated Financial Statements and Other Information
For the Year Ended December 31, 2015

This document is dated May 13, 2016

TABLE OF CONTENTS

CERTAIN STATEMENTS INCLUDED OR INCORPORATED BY REFERENCE IN THIS ANNUAL REPORT CONSTITUTE FORWARD-LOOKING STATEMENTS THAT INVOLVE RISKS AND UNCERTAINTIES. ACTUAL RESULTS MAY DIFFER SIGNIFICANTLY FROM THE RESULTS DISCUSSED IN THE FORWARD-LOOKING STATEMENTS AS A RESULT OF KNOWN AND UNKNOWN RISKS, UNCERTAINTIES AND OTHER FACTORS WHICH MAY CAUSE ACTUAL RESULTS, PERFORMANCE OR ACHIEVEMENTS DESCRIBED TO BE MATERIALLY DIFFERENT FROM ANY FUTURE RESULTS, PERFORMANCE OR ACHIEVEMENTS EXPRESSED OR IMPLIED BY SUCH FORWARD-LOOKING STATEMENTS. AURORA HEALTH CARE, INC. DOES NOT PLAN TO ISSUE ANY UPDATES OR REVISIONS TO THOSE FORWARD-LOOKING STATEMENTS IF OR WHEN THE EXPECTATIONS OR EVENTS, CONDITIONS OR CIRCUMSTANCES ON WHICH SUCH STATEMENTS ARE BASED OCCUR.

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, 2015.

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 and northern Illinois, 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 brought its own insurance product to market, "The Aurora Network." The network is comprised of Aurora hospitals and clinics, physicians employed by Aurora, and certain other independent physicians which offers a unique value proposition, including a price guarantee to employers. Aurora also partnered with an insurance company during 2016 to form a jointly owned health insurance company, Wisconsin Collaborative Insurance Company. In addition, Aurora is also a partner in the "AboutHealth" strategic partnership. This partnership includes eight health care organizations in Wisconsin and was developed to build upon and advance the clinical quality, efficiency, and customer experience attributes that are shared among the organizations. An initial commercial insurance plan featuring the eight organizations will be offered through Anthem Blue Cross Blue Shield’s Priority network.

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 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 and northern Illinois, 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"), approximately 160 physician clinic facilities (collectively, the "Aurora Clinic Facilities"), one of the largest home health care organizations in Wisconsin, 70 retail pharmacies, and other health care and related services.

For the year ended December 31, 2015, Aurora provided services to approximately 1.2 million patients in approximately 7.1 million patient encounters. During that same period, it reported adult inpatient days of approximately 442,000; admissions of approximately 101,000; and physician clinic, hospital outpatient and other visits of 7.1 million. Aurora had $4.9 billion in assets as of December 31, 2015 and total operating revenue of approximately $4.9 billion for the year ended December 31, 2015. At December 31, 2015, Aurora employed approximately 1,730 physicians.

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

- Truven Health Analytics (March 2016): Top 100 Hospital among medium community hospitals (Aurora BayCare Medical Center); Top 100 Hospital among small community hospitals (Aurora Medical Center Manitowoc County).
- HealthCare's Most Wired (July 2015): Winner 2015, 12th consecutive year.
- Best Regional Hospitals Ranking (July 2015): (Aurora St. Luke's Medical Center); Nationally Ranked Specialties (Aurora St. Luke's Medical Center – four specialties); High Performing Specialties (Aurora St. Luke's Medical Center - seven specialties).
- The Joint Commission (2014): Top Performers on Key Quality Measures (eight Aurora Hospital Facilities).
- 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 throughout its service area 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. The implementation of SmartChart was completed during 2013 at a total cost of approximately $93 million. 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. As a high-quality, low-cost provider, Aurora is well positioned for health care reform. To date, Aurora has exceeded management's expectations on the value-based purchasing provisions of health care reform (earning full reimbursement at 12 out of Aurora's 14 acute-care hospitals).

Aurora's strategic partnership with other health care organizations in Wisconsin, "AboutHealth", has continued to expand its presence during 2015. In May of 2015, Marshfield Clinic Health System joined AboutHealth. The partnership was developed to build upon and advance the clinical quality, efficiency and customer experience attributes that are shared among the eight organizations. The other members of the partnership include Aspirus, Bellin Health, Gundersen Health System, Marshfield Clinic, ProHealth Care, ThedaCare, and UW Health. Most organizations in the partnership use the same technology for electronic medical records, making it easier for patients to access their records and share with doctors in the network. An initial commercial insurance plan featuring the eight organizations is being offered through Anthem Blue Cross Blue Shield's Priority network.

Aurora has also entered into a partnership with Marquette University to build and staff a state-of-the-art Athletic Performance Research Center. Under the terms of the agreement, Aurora will make a $40 million capital investment 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 exceptional 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 our collaboration will help develop and drive innovations around community health and population health initiatives.

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 3,065 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. However, Aurora's continued recruitment and solid rate of physician retention has resulted in a stable employed and closely aligned physician count. In 2015, revenue generated from employed and closely aligned physicians accounted for approximately 75% of Aurora's net patient service revenue.

Insurance Products: Aurora developed The Aurora Network (formerly known as the Aurora Accountable Care Network or AACN), a network comprised of Aurora hospitals and clinics, physicians employed by Aurora and certain other independent physicians which offers a unique value proposition, including a price guarantee to employers built upon a health care model that improves 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 small and medium-sized employers. Aurora has also developed products for large, self-funded employers. In 2015, 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.

In April of 2016, Anthem Blue Cross and Blue Shield in Wisconsin ("Anthem") and Aurora partnered to form 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 best-in-class care delivery system with Anthem's insurance expertise to create a new and better way of delivering health care to consumers. The plan, which utilizes a patient-centered approach to care, is designed to deliver lower overall cost of care, healthier consumers and higher patient satisfaction.

Well Priority products will utilize Anthem's Blue Priority network. Health systems participating in Blue Priority include: Aspirus, Bellin Health, Children's Hospital of Wisconsin, Gundersen Health System, ProHealth Care, ThedaCare, UW Health, UnityPoint Health - Meriter in Madison, and select clinics and physicians to ensure access across the entire geography covered by the network.

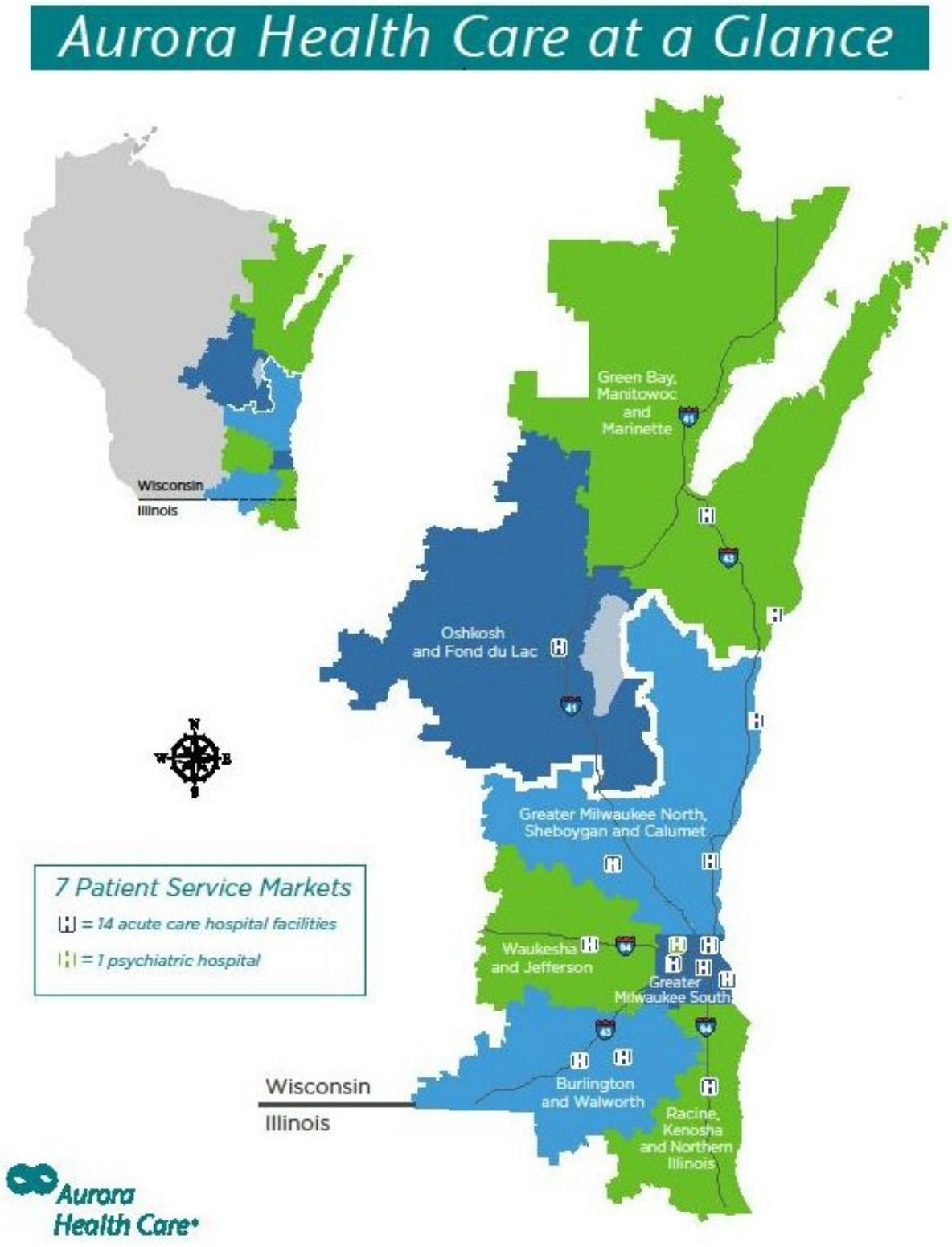
Aurora has significant experience in population health management, having successfully managed approximately 46,000 covered lives during the last 5 years (including its employees and their dependents), achieving an average rate decrease for per-member-per-month costs of 1.0% from 2014 to 2015 (as compared to the national average that has historically risen 8-9% annually per benchmarks by Mercer). Building on this experience, Aurora developed The Aurora Network, a network built upon a

health care model that improves 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 small and medium-sized employers. Aurora has also developed products for large, self-funded employers. In 2015, 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, 2015, Aurora is currently managing approximately 25,000 covered lives for approximately 320 different employers under The Aurora Network and approximately 73,000 covered lives through products offered on the health insurance exchange in addition to its covered employees and their dependents.

BUSINESS STRATEGY

Aurora is committed to stewardship in the communities it serves by providing high quality and cost effective patient care while increasing its financial stability. Aurora has developed a strategic plan focusing on "*Best Brand*", "*Best Value*", and "*Best People*" to achieve these objectives, including:

- Strategically growing its presence in existing markets;
- Achieving industry-leading performance in clinical and satisfaction measures;
- Strengthening the Aurora brand;
- Expanding its presence in the insurance market and investing in technology;
- Continuing to leverage its scale and market position; and
- Pursuing strategic growth opportunities.



Behavioral Health is an additional PSM which is not defined by geographical boundaries and therefore is not separately illustrated on the map above.

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 60.4% of the State's population), as well as portions of two counties in northern Illinois that are contiguous to the Wisconsin border.

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 PSMs are managed by region, North and South, as reflected below. The population of each PSM as of December 31, 2015 and the percentage of Aurora's total revenues generated by each PSM for the year ended December 31, 2015 are listed below.

PSM	Population[(1)]	Percentage of Total Revenue for Year ended December 31, 2015
North Region		
Green Bay, Manitowoc and Marinette	565,000	12%
Oshkosh and Fond du Lac	498,000	5%
South Region		
Greater Milwaukee South	595,000	44%
Greater Milwaukee North, Sheboygan and Calumet	946,000	20%
Burlington and Walworth	266,000	6%
Racine, Kenosha and Northern Illinois	287,000	7%
Waukesha and Jefferson	311,000	5%
Behavioral Health[(2)]	N/A	1%

[(1)] Source - 2015 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 1,992 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. Aurora Grafton is exempt from federal income taxation pursuant to Sections 501(a) and 501(c) of the Internal Revenue Code.

The following table summarizes the Aurora Hospital Facilities as of December 31, 2015 categorized by PSM:

Facility/PSM	Location	Licensed Beds	Available Beds
Greater Milwaukee South			
Aurora St. Luke's Medical Center	Milwaukee	938	629
Aurora St. Luke's South Shore	Cudahy	275	103
Aurora West Allis Medical Center	West Allis	350	195
Aurora Sinai Medical Center	Milwaukee	386	137
Sheboygan, Calumet and Greater Milwaukee North			
Aurora Sheboygan Memorial Medical Center	Sheboygan	185	136
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	62
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	81
Totals		**3,162**	**1,992**

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, 2015, Aurora St. Luke's Medical Center represented 24% of the total revenue of Aurora.

Aurora St. Luke's Medical Center is one of the state's volume leaders for key specialties including cardiac, neurological and orthopedic services. It was named in the U.S. News & World Report's 2015 best hospital rankings for the Milwaukee area and was nationally recognized in four 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 is nationally recognized for providing quality care in the area of cancer by the Commission on Cancer, Blue Cross Blue Shield, and Foundation for Stem Cell Transplantation and the American College of Surgeons.

Aurora Clinic Facilities. The following table summarizes the clinic facilities operated by Aurora as of December 31, 2015, categorized by PSM.

Facility/PSM	**Number of Clinic Sites**
Greater Milwaukee South	34
Sheboygan, Calumet and Greater Milwaukee North	28
Greater Green Bay, Manitowoc and Marinette	28
Oshkosh and Fond du Lac	12
Burlington and Walworth	12
Racine, Kenosha and Northern Illinois	12
Waukesha and Jefferson	5
Other Affiliates	19
Behavioral Health	8
Total	158

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, 2015, the Aurora Hospital Facilities in Greater Milwaukee South and Waukesha accounted for approximately 40% of the total PSM adult acute care admissions and approximately 60% 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 years ended December 31, 2015, 2014 and 2013.

Percentage of Adult Acute Care Admissions by PSM

		December 31	
	June 30, 2015[1]	**2014**	**2013**
Greater Milwaukee South, Waukesha and Jefferson [2]**:**			
Aurora	40%	39%	39%
Froedtert & Community Health	24	24	23
Wheaton Franciscan Healthcare [4]	17	17	18
Columbia – St Mary's [4]	8	8	8
ProHealth Care, Inc.	11	12	12
	100%	100%	100%
Greater Green Bay, Manitowoc and Marinette:			
Aurora	30%	30%	28%
Bellin Health	24	24	24
Hospital Sister's Health System	38	38	40
Franciscan Sister of Christian Charity	8	8	8
	100%	100%	100%
Oshkosh and Fond du Lac:			
Aurora	39%	38%	37%
Affinity Health System [4]	61	62	63
	100%	100%	100%
Sheboygan, Calumet, and Greater Milwaukee North:			
Aurora	54%	53%	55%
Hospital Sister's Health System	10	10	11
Columbia – St Mary's [4]	21	22	20
Froedtert & Community Health	15	15	14
	100%	100%	100%
Burlington and Walworth:			
Aurora	83%	83%	84%
Mercy Health System	17	17	16
	100%	100%	100%
Racine, Kenosha and Northern Illinois [3]**:**			
Aurora	19%	18%	17%
Wheaton Franciscan Healthcare [4]	49	50	51
United Health System	32	32	32
	100%	100%	100%

(1) Source: Wisconsin Hospital Association: Inpatient Admissions - 2015 based on all payer types, including charity care. Most recent data is as of June 30, 2015. 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) Affiliated with Ascension Health.

Historical Utilization

The following table summarizes utilization statistics for Aurora for the years ended December 31, 2015, 2014, and 2013:

	Year Ended December 31,		
	2015	**2014**	**2013**
Adult inpatient days	442,413	435,187	425,524
Adult average daily census	1,212	1,192	1,166
Adult average length of stay	4.4	4.4	4.3
Adult discharges	100,888	98,533	100,083
Emergency room visits	366,253	347,549	259,623
Observation and bedded outpatients	36,925	35,228	30,628
Surgical cases	111,208	107,388	103,875
Physician clinic, hospital outpatient and other visits (includes emergency room visits)	7,124,035	6,833,592	6,244,721

Sources of Patient Service Revenue

Patient service revenue realized 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 insurance plans. Currently, approximately 75% 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, 2015, 2014, 2013:

	Year Ended December 31,		
	2015	**2014**	**2013**
Managed Care and all other	63%	62%	59%
Medicare	27	28	29
Medicaid	8	9	7
Self-pay	2	1	5
	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 PSMs 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 56% of its medical staff, including approximately 1,730 physicians in over 64 different specialties. Total medical staff, including employed physicians, is currently comprised of approximately 3,065 physicians, with just over 68% of the medical staff considered specialists. During 2015, approximately 75% 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, 2015, Aurora had approximately 31,000 employees, representing approximately 27,000 full-time equivalent staff. Aurora is one of the largest private employers in the State of Wisconsin. As of December 31, 2015, approximately 131 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 the University of Wisconsin - Madison Medical School and the Medical College of Wisconsin, located in Milwaukee. There are approximately 425 medical student rotations and 179 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 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.

The Corporation 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, 2015, 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, 2015, 2014 and 2013, assets held in the trust were $54.1 million, $55.3 million, and $58.3 million, respectively, and the estimated liability for claims, including incurred but not reported, and future servicing costs were $37.9 million, $39.2 million, and $38.4 million, respectively.

Workers' Compensation. The Corporation also provides statutory workers' compensation insurance for employees. As of December 31, 2015, through the workers' compensation insurance policy with Sentry Casualty Company, the Corporation assumed the first $0.4 million per occurrence for workers' compensation claims. 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, the Corporation 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 which the Corporation evaluates periodically.

Community Benefit

Aurora exists to benefit the people in the communities it serves and to carry out its purpose to help people live well. In pursuing its purpose, Aurora advocates for and provides services to help meet healthcare 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.

In addition, 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, 2015, 2014 and 2013, is as follows (in thousands):

	2015	2014	2013
Cost of charity care provided	$ 29,771	$ 64,104	$ 56,426
Unpaid cost of Medicaid	320,475	257,464	302,199
Unpaid cost of other public Programs	9,452	9,650	6,924
Total Cost of uncompensated care	359,698	331,218	365,549
Community health improvement and education services and Community Benefit operations	7,865	11,152	8,813
Health professional education	10,463	10,768	13,934
Subsidized health services	9,255	13,013	8,062
Cash and in-kind contributions for community benefit	8,149	5,700	8,881
Total community benefit programs	35,732	40,633	39,690
Unpaid cost of Medicare	579,806	472,823	426,857
Total cost of uncompensated care, community benefit programs and unpaid cost of Medicare	$ 975,236	$ 844,674	$ 832,096

Aurora in partnership with the Greater Milwaukee Foundation established the "Better Together Fund" to focus on specific areas of community need. In 2014, Aurora made a $10.0 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 2015, Aurora made additional contributions to the "Better Together Fund" of $3.8 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 have been instituted or asserted against it from time to time. While it is impossible to predict the likelihood of future claims or inquiries, Aurora expects that new matters will be initiated against it in regular course. 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,

may have a material adverse effect on Aurora's business, financial position, results of operations, or cash flows.

Implantable Cardioverter Defibrillators ("ICDs") Investigations – In 2010, the Department of Justice served subpoenas on and issued letters to a number of hospitals and health systems across the country, including Aurora, as part of a fraud investigation into whether hospitals billed Medicare for ICDs for patients whose conditions did not satisfy coverage criteria set forth in the Center for Medicare and Medicaid Services National Coverage Determination. Management of Aurora cooperated fully with the investigation and reached a settlement with the Department of Justice during the third quarter of 2015. The resolution of this investigation did not have a material adverse effect on Aurora's financial position, results of operations, or cash flows.

There are currently no pending legal proceedings and investigations that are not in the ordinary course of business, within applicable insurance coverages, or for which management has determined the amount of ultimate liability with respect to such proceedings and investigations will materially affect Aurora's consolidated results of operations or net assets.

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 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 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.

Financial Reporting Initiatives

In 2013, Aurora began an initiative to evaluate its internal control environment and to create efficiencies in Aurora's financial reporting processes. The initiative 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 goals of the initiative are to ensure the integrity and reliability of financial information, strengthen internal controls in the reporting process, reduce the risk of fraud and improve efficiencies in the financial reporting process. The initiative includes the review of all aspects of the financial reporting process, identify 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, 2015, 2014 and 2013, 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, 2015, 2014 and 2013, 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" site 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		
	2015	**2014**	**2013**
Cash and cash equivalents	$ 176,626	$ 238,772	$ 310,076
Investments	1,272,107	1,157,604	847,904
Assets whose use is limited or restricted	10,793	5,560	5,652
Patient accounts receivable — net	760,058	613,971	520,617
Other receivables	81,626	74,490	75,904
Inventory	67,572	64,805	64,760
Prepaids and other current assets	56,728	39,885	38,359
Estimated third-party payor settlements	7,494	9,361	—
Total current assets	2,433,004	2,204,448	1,863,272
Assets whose use is limited or restricted	375,551	381,003	369,217
Property, plant, and equipment, net	1,955,988	1,869,492	1,857,437
Intangible assets — net	16,245	18,884	24,596
Investments in unconsolidated entities	73,788	66,135	12,839
Other assets	48,410	41,484	36,028
Total Assets	$ 4,902,986	$ 4,581,446	$ 4,163,389
Current installments of long-term debt	$ 136,542	$ 56,882	$ 119,125
Accounts payable	228,344	201,593	222,843
Accrued salaries and wages	277,070	310,848	301,208
Other accrued expenses	203,344	179,804	196,216
Estimated third-party payor settlements	22,061	22,446	33,480
Total current liabilities	867,361	771,573	872,872
Long-term debt, less current installments	1,421,061	1,557,352	1,518,644
Pension and other employee benefit liabilities	225,428	282,442	198,876
Self-insured liabilities	64,898	63,934	62,314
Deferred gain	41,863	47,364	52,864
Other	65,191	67,360	58,606
Total liabilities	2,685,802	2,790,025	2,764,176
Unrestricted net assets:			
Controlling interest	2,066,225	1,639,621	1,261,395
Noncontrolling interest in subsidiaries	88,447	86,631	77,447
Total unrestricted net assets	2,154,672	1,726,252	1,338,842
Temporarily restricted net assets	43,779	46,697	42,033
Permanently restricted net assets	18,733	18,472	18,338
Total net assets	2,217,184	1,791,421	1,399,213
Total Liabilities and Net Assets	$ 4,902,986	$ 4,581,446	$ 4,163,389

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

	Year Ended December 31,		
	2015	**2014**	**2013**
REVENUE:			
Patient service revenue	$ 4,647,940	$ 4,361,800	$ 4,106,789
Less provision for bad debts	132,805	56,402	221,135
Net patient service revenue	4,515,135	4,305,398	3,885,654
Other revenue	414,912	410,695	363,321
Total revenue	4,930,047	4,716,093	4,248,975
EXPENSES:			
Salaries, wages and fringe benefits	2,564,106	2,465,092	2,390,509
Professional fees	79,893	75,527	84,949
Supplies	929,228	818,862	754,759
Depreciation and amortization	198,644	205,798	229,576
Interest	57,378	63,602	66,817
Maintenance and service contracts	111,637	100,623	98,537
Building and equipment rental	71,087	76,892	83,975
Hospital tax assessment	94,739	94,396	94,394
Utilities	47,118	47,690	46,727
Purchased services	123,854	112,785	96,047
Other expenses	153,111	151,801	145,864
Pension settlement loss	36,848	—	—
Total expenses	4,467,643	4,213,068	4,092,154
OPERATING INCOME	462,404	503,025	156,821
NONOPERATING INCOME (LOSS):			
Investment income	(1,949)	35,341	31,456
Other nonoperating (loss) income - net	(17,725)	758	6,682
Total nonoperating income — net	(19,674)	36,099	38,138
Excess of revenue over expenses from continuing operations [(1)]	442,730	539,124	194,959
Income from discontinued operations	—	—	1,046
Pension-related changes other than periodic pension cost	25,234	(113,706)	252,111
Net assets released from restriction for purchase of property and equipment	2,643	1,341	2,606
Distributions to noncontrolling interests	(42,581)	(39,260)	(26,886)
Other	394	(89)	933
Increase (decrease) in unrestricted net assets	$ 428,420	$ 387,410	$ 424,769

(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 from continuing operations includes $44.4 million million, $48.4 million, and $38.5 million for the years ended December 31, 2015, 2014, and 2013, 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, 2015, 2014 and 2013:

	Year Ended December 31,		
	2015	**2014**	**2013**
Operating Performance:			
Operating margin [1]	9.4%	10.7%	3.7%
EBIDA percent [2]	14.2%	17.1%	11.6%

	As of December 31,		
	2015	**2014**	**2013**
Liquidity:			
Days cash on hand [3]	137.0	141.8	125.2
Net AR days outstanding [4]	61.4	52.1	49.0
Financial Position/Leverage Ratios:			
Unrestricted cash to debt [5]	103%	96%	80%
Cash to puttable debt [6]	327%	341%	286%
Debt to capitalization [7]	42%	49%	55%
Debt to cash flow [8]	2.4	2.2	3.9
Debt service coverage ratio [9]	6.0x	6.8x	4.1x

[1] Operating income /Total revenue.

[2] (Excess of revenues over expenses from continuing operations + 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 from continuing operations + Depreciation and amortization expense).

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

The Obligated Group

The Corporation and certain of its affiliates set forth below (collectively, the "Obligated Group") have agreed to be jointly and severally obligated for Master Notes issued under a Second Restated Master Trust Indenture, dated January 1, 2012, between the Obligated Group and U.S. Bank National Association, as Master Trustee (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 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, 2015, 2014 and 2013 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, 2015, 2014 and 2013, is as follows (in thousands):

	December 31,					
	2015		2014		2013	
Total Revenue						
Obligated Group	$ 3,524,330	71%	$ 3,388,261	72%	$ 3,046,235	72%
Non-Obligated Group	1,405,717	29%	1,327,832	28%	1,202,740	28%
Consolidated System	$ 4,930,047	100%	$ 4,716,093	100%	$ 4,248,975	100%
Total Assets [(1)(2)]						
Obligated Group	$ 4,151,474	85%	$ 3,922,401	86%	$ 3,494,682	84%
Non-Obligated Group	751,512	15%	659,045	14%	668,707	16%
Consolidated System	$ 4,902,986	100%	$ 4,581,446	100%	$ 4,163,389	100%
Total Net Assets [(1)(2)]						
Obligated Group	$ 1,599,011	72%	$ 1,223,637	68%	$ 865,687	62%
Non-Obligated Group	618,173	28%	567,784	32%	533,526	38%
Consolidated System	$ 2,217,184	100%	$ 1,791,421	100%	$ 1,399,213	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 is $239.8 million, $170.9 million, and $247.9 million as of December 31, 2015, 2014, and 2013, 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 $152.5 million, $191.8 million, and $184.8 million as of December 31, 2015, 2014, and 2013, 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, 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 incurred in the current year, further discussed below. Nonoperating loss was $19.7 million in 2015 compared to $36.1 million of nonoperating income for the same period 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 significantly 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 modestly primarily due to increased pharmacy revenue under the 340B program offset by losses related to the 457B 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.

Results of Operations – Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Operating income was $503.0 million in 2014, resulting in an operating margin of 10.7%, as compared to operating income of $156.8 million and an operating margin of 3.7% in 2013. The higher operating income in 2014 was due to higher volumes, an increase in net revenue realization rates, the impact of changes to prior year estimates and certain margin optimization activities implemented primarily in the revenue cycle beginning in the second half of 2013. Nonoperating income was $36.1 million in 2014 compared to $38.1 million for the same period in 2013. The decrease from the prior period is primarily due to a $7.4 million gain recognized in the prior year on the restructuring of Aurora's investment in Premier, Inc., Aurora's group purchasing organization, offset by a $3.9 million increase in investment income attributable to overall changes in the financial markets. Overall, Aurora reported an excess of revenue over expenses from continuing operations of $539.1 million in 2014 compared to $195.0 million for the same period in the prior year.

Patient service revenue increased $255.0 million (6.2%) in the year ended December 31, 2014, compared to the same period in 2013. Patient service revenue increased due to an increase in volume with adult inpatient days, observation and bedded outpatients, and physician clinic, hospital outpatient and other visits increasing 2.3%, 15.0%, and 9.4%, respectively, for the year ended December 31, 2014 as compared to the same period in the prior year. The increase in patient service revenue was also due to an increase in the realization rates due to additional reimbursement received for previously uninsured and underinsured patients that are now insured under commercial insurance products from the health insurance exchanges, childless adults who now qualify for Medicaid, and $24.6 million of additional reimbursement received in the current year due to increased Medicaid provider attestation reimbursement which was retroactive to January 1, 2013. Additionally, patient service revenue increased $42.9 million due to changes in estimates related to prior periods for better than expected collections on the legacy

physician billing system and changes to recorded estimated third-party settlements compared to $33.2 million for the same period in the prior year.

Provision for bad debts decreased $164.7 million (74.5%) in the year ended December 31, 2014, compared to the same period in the prior year. Charity care and bad debt as a percentage of patient service revenue net of contractual allowances and discounts (before charity care) have also decreased from 9.3% for the year ended December 31, 2013 to 6.0% for the year ended December 31, 2014. The decrease is due to an increase in the uninsured discount offered to self-pay patients to 45% from 15% beginning November 1, 2013 thus reducing the amount due from the patient and minimizing the risk of not collecting payment. The decrease is also due to a change in the charity care process implemented during the fourth quarter of 2013 to better identify patients who have met the charity care requirements which resulted in an increase in charity care of $37.9 million of foregone charges for the year ended December 31, 2014 compared to the same period of the prior year. In addition, a decrease in self-pay patients also contributed to the reduction in the provision for bad debts as self-pay receivables are typically reserved at a higher rate as there is a higher risk of not receiving payment for services performed. The decrease in self-pay patients is due to childless adults with incomes under 100% of the Federal Poverty Level now being eligible for the State of Wisconsin Medicaid program beginning April 1, 2014 and previously uninsured and underinsured patients that are now insured under commercial insurance products from the health insurance exchanges.

Other revenue increased $47.4 million (13.0%) in the year ended December 31, 2014, compared to the same period in the prior year. The increase in other revenue is primarily due to a $32.3 million increase in pharmacy revenue as a result of an increase in utilization of specialty pharmacy supplies. Other revenue also increased $19.0 million due to higher drug sales under the 340B contract pharmacy program which has expanded during the current year.

Operating expenses, excluding depreciation and amortization and interest, as a percentage of total revenue, decreased from 89% to 80% from 2013 to 2014, respectively, due to various cost containment efforts.

Salaries, wages and fringe benefits expense increased $74.6 million (3.1%) in the year ended December 31, 2014, compared to the same period in the prior year. Salaries and wages primarily increased due to the annual salary adjustment of 2.8% which became effective in July of 2014. The increase is also due to $12.2 million of discretionary caregiver thank-you compensation, $10.9 million of additional physician compensation as a result of Medicaid provider attestation and a 1.7% increase in full time equivalents.

Professional fees decreased $9.4 million (11.1%) in 2014, compared to 2013. The decrease is primarily due to previously contracted hospitalists that are now employed by Aurora.

Supplies expense increased $64.1 million (8.5%) in the year ended December 31, 2014, compared to the same period in the prior year. A change in the fixed asset capitalization policy was made on January 1, 2014, to increase the threshold to measure an expenditure for capitalization from $1,000 to $5,000 and exclude group purchases. This change in policy increased supplies expense by $20.5 million for the year ended December 31, 2014. The remaining increase is due to higher volume period over period offset by a $7.5 million reduction in supplies expense due to the restructuring of Aurora’s investment in Premier, Inc.

Excluding the impact of the previously noted change in capitalization policy, supplies expense as a percent of total revenue has decreased from 17.8% for the year December 31, 2013 to 17.0% for the year ended December 31, 2014 due to various cost containment efforts.

Depreciation and amortization expense decreased $23.8 million (10.4%) in the year ended December 31, 2014, compared to the same period in the prior year. This decrease is largely due to accelerated depreciation recorded during 2013 related to Cerner, Aurora's previous electronic medical record system. Cerner was replaced with SmartChart which was implemented systemwide by October 2013.

Interest expense decreased $3.2 million (4.8%) in the year ended December 31, 2014, compared to the same period in the prior year. This decrease is attributable to the remarketing of certain bonds in August of 2014 and market driven fluctuations in the interest rates on Aurora's variable rate debt, which approximated 28% of Aurora's total debt as of December 31, 2014.

Building and equipment rental decreased $7.1 million (8.4%) in the year ended December 31, 2014, compared to the same period in the prior year. This decrease is primarily due to a $7.6 million decrease in equipment rental as a result of a strategic initiative to purchase previously leased equipment.

Purchased services increased $16.7 million (17.4%) in the year ended December 31, 2014, as compared to the prior year. This increase is attributable to a variety of outside services such as employee sublease expense, grounds maintenance, lab management fees, marketing and other expenses.

Other expenses increased $5.9 million (4.1%) in the year ended December 31, 2014, as compared to the prior year. This increase is due to $8.3M of contributions made by Aurora during 2014 to a "Better Together Fund" to support 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.

All other expenses, including maintenance and service contracts, hospital tax assessment, and utilities, remained relatively consistent in the year ended December 31, 2014 as compared to the year ended December 31, 2013, increasing $3.1 million (1.3%) 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, 2015 and 2014 (dollars in thousands):

	December 31, 2015		December 31, 2014		December 31, 2013	
Cash and cash equivalents	$ 203,057	11.2%	$ 268,499	15.0%	$ 336,370	21.9%
Fixed-income securities:						
U.S. Treasury	80,456	4.4%	81,179	4.6%	126,623	8.3%
Corporate bonds and other debt securities	187,999	10.2%	217,598	12.2%	304,938	19.9%
Federal agency	89,889	4.9%	106,355	6.0%	138,100	9.0%
Fixed income mutual funds	793,033	43.2%	894,656	50.2%	418,468	27.3%
Domestic equity securities:						
Large-cap	16,156	0.9%	20,533	1.2%	24,258	1.6%
Mid-cap	11,006	0.6%	10,977	0.6%	11,315	0.7%
Small-cap	19,124	1.0%	21,794	1.2%	20,888	1.4%
Real estate	279	—%	332	—%	2,285	0.1%
Equity mutual funds and exchange-traded funds	300,598	16.4%	80,435	4.5%	81,252	5.3%
Real estate investments	12,774	0.7%	11,042	0.6%	—	—%
International equity securities	107,183	5.8%	52,730	3.0%	50,035	3.3%
International equity limited partnerships	7,840	0.4%	9,691	0.5%	9,738	0.6%
Other	5,683	0.3%	7,118	0.4%	8,579	0.6%
Total	1,835,077		1,782,939		1,532,849	
Less restricted investments [1]	(232,852)		(226,156)		(208,352)	
Total unrestricted cash and investments	$ 1,602,225		$ 1,556,783		$ 1,324,497	
Days cash on hand [2]	137.0		141.8		125.2	

[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 $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.

Aurora's unrestricted cash and investments increased by $232.3 million or 17.5% from December 31, 2013 to December 31, 2014. The increase in unrestricted cash and investments from December 31, 2013 to December 31, 2014 was primarily due to $538.6 million of cash flow generated from operations offset by a net $44.5 million of investments in unconsolidated entities, a net $56.1 million of scheduled

principal payments on long-term debt, $39.3 million of distributions to minority shareholders, and $172.3 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 (loss) income for Aurora for the years ended December 31, 2015, 2014 and 2013 consisted of the following (in thousands):

	2015	2014	2013
Interest income and dividends	$ 41,179	$ 30,225	$ 19,455
Net realized gains on securities	3,442	11,358	31,921
Changes in unrealized (losses) gains on investments	(47,351)	2,431	(972)
Total	$ (2,730)	$ 44,014	$ 50,404

Liquidity – Accounts Receivable

Net accounts receivable days outstanding increased from 52.1 days as of December 31, 2014 to 61.4 days as of 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.

Net accounts receivable days outstanding increased from 49.0 days at December 31, 2013 to 52.1 days at December 31, 2014. The primary reason for the increase in net accounts receivable days outstanding was due to system access issues affecting the productivity of Aurora's coders.

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, 2015, 2014 and 2013, the aggregate principal amount of the Revenue Bonds outstanding was as follows (in thousands):

	2015	2014	2013
Fixed rate revenue bonds	$ 692,737	$ 764,774	$ 795,839
Long-term rate revenue bonds	132,475	132,475	132,475
Variable rate revenue bonds	449,705	456,725	462,485
Total	$ 1,274,917	$ 1,353,974	$ 1,390,799

Fixed Rate Revenue Bonds: At December 31, 2015, 2014, and 2013, the Corporation had outstanding $692.7 million (including $12.7 million of unamortized original premium, net), $764.8 million (including $14.0 million of unamortized original premium, net), and $795.8 million (including $15.5 million of unamortized original premium, net) of Fixed Rate Bonds, respectively. The weighted average interest rate on the Fixed Rate Revenue Bonds was 5.14%, 5.12%, and 5.10% at December 31, 2015, 2014, and 2013, respectively.

Long-Term Rate Bonds: The 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. There is no liquidity facility in effect with respect to the Long-Term Rate Bonds to pay the purchase price on the mandatory tender dates. 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
Series 2009B-2	$67,475	August 15, 2016

There is no liquidity facility in effect with respect to the long-term rate bonds to pay the purchase price on the mandatory tender dates. 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, 2015, $67.5 million of the long-term bonds are classified as current due to these requirements. The remainder of the long-term rate bonds were classified as long-term at December 31, 2015.

The 2009B-1 bonds were remarketed on August 15, 2014, as long-term rate bonds with a fixed interest rate of 1.25% and an initial mandatory tender date of August 15, 2017.

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, 2015, 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. In December 2015, the letter of credit associated with the 2010C bond was extended from an initial termination date of December 9, 2016 to a subsequent termination date of January 31, 2019 (as set forth in the table below). Principal payments for any advances under each of the Letters of Credit begin the earlier of one year from the date of the advance and two months after the expiration date of the Letter of Credit. The principal payments for any advance under the Letters of Credit amortize over a two or three-year period. 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 America	108,544	01/31/2019
Bank of Montreal	39,945	2/7/2018
Bank of Montreal	39,945	2/7/2018
Bank of Montreal	59,517	2/7/2018
Total	$ 466,982	

Line of Credit. At December 31, 2015, 2014, and 2013, 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, 2015, 2014, and 2013, two letters of credit issued under the line of credit totaling $37.7 million, $36.3 million, and $33.3 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, 2015, 2014 and 2013, the outstanding amount of capital lease obligations and financing arrangements was $239.6 million, $256.5 million and $248.5 million, respectively.

Aurora is also obligated under a term note and various other debt. The term note is an obligation of Aurora BayCare and is 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.

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, 2015, 2014 and 2013 is as follows (in thousands):

	December 31,		
	2015	**2014**	**2013**
Total revenue bonds	$ 1,274,917	$ 1,353,974	$ 1,390,799
Capital lease obligations and financing arrangements	239,646	256,526	248,505
Taxable bond	40,000	—	—
Term note	10,264	11,075	11,884
Various notes payable	6,573	8,398	3,956
Deferred financing costs - net	(13,797)	(15,739)	(17,375)
Total long-term debt	$ 1,557,603	$ 1,614,234	$ 1,637,769

Interest Rate Swap Agreement

Aurora has 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 (Aurora Health Care Obligated Group), maturing in August 2023 (the "Series 1993 Bonds"). During the term of the Swap Agreement, Aurora continues to pay interest on the Series 1993 Bonds at their fixed interest rates, and pays 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 receives 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, 2014, and 2013 the fair value of the Swap Agreement was a liability of $2.4 million, $2.6 million, and $2.7 million, respectively.

The Swap Agreement terminates in February 2018. The terms of the Swap Agreement require Aurora to transfer collateral to MLCS if its liability, determined on a mark-to-market basis, exceeds a specified threshold that varies based on the rating of the Series 1993 Bonds. Aurora's payment obligations under the Swap Agreement are secured by an Obligation issued under the Master Indenture. As of December 31, 2015, 2014 and 2013, no collateral was required.

The Corporation received net swap payments of $3.9 million, $3.9 million and $3.8 million during the years ended December 31, 2015, 2014 and 2013, respectively.

Capital Expenditures

In 2015, 2014, and 2013, Aurora's capital expenditures were $296.7 million, $172.3 million, and $128.1 million, respectively. The increase in capital expenditures since 2013 reflects Aurora's focus on strategic capabilities and growth. Current projects underway in 2015 include construction of a new ambulatory surgery center in Burlington, Wisconsin, infrastructure to support a second data center and various hospital and clinic renovation and expansion projects.

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 2015 and those budgeted for 2016 reflect a continued shift in capital allocation from information technology to strategic capabilities and growth, as shown below. Although we continue to invest in information technology we anticipate that more of these costs will be expensed in 2016 as we move to more software as a service.

	Actual 2015	Budget 2016
Strategic capabilities and growth	38.5%	50.3%
Routine replacement	31.3%	19.1%
Information technology	13.5%	7.9%
System (Diagnostic, Facilities & Nursing)	16.7%	22.7%
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 $458 million in 2016, 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. 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. 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, 2015, 2014 and 2013 of $32.8 million, $0.7 million, and $(4.1) 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 2015, 6.25% in 2014, and 7.50% in 2013. The discount rate used to measure the projected benefit obligation was 4.70%, 4.32%, and 5.22% as of December 31, 2015, 2014, and 2013, 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:

	2015		2014		2013	
	Strategic Target	Actual	Strategic Target	Actual	Strategic Target	Actual
Equity securities	33%	32%	33%	36%	33%	36%
Fixed-income securities	64	65	64	60	64	60
Real estate	3	3	—	2	—	—
Cash and cash equivalents	—	—	3	2	3	4
Total	100%	100%	100%	100%	100%	100%

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 a $72.3 million contribution made to the Pension Plan, 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.

At the December 31, 2014 measurement date, the projected benefit obligation in excess of the fair value of plan assets for the Pension Plan was $182.7 million (88.4% funded) compared to $112.2 million (91.5% funded) at December 31, 2013. This increase in unfunded pension liability resulted from a

decrease in the discount rate from 5.22% at December 31, 2013 to 4.32% at December 31, 2014, and adoption of the 2014 Society of Actuaries mortality tables which increased Aurora's pension obligation $52.1 million.

Pension-related changes other than net periodic pension costs increased net assets by $25.2 million for the year ended December 31, 2015, decreased net assets by $113.7 million for the year ended December 31, 2014 and increased net assets by $252.1 million for the year ended December 31, 2013.

Aurora contributed $72.3 million, $43.9 million, and $121.8 million to the Pension Plan during the years ended December 31, 2015, 2014, and 2013, respectively. Aurora plans to continue to fund the Pension Plan to meet the minimum required funding levels. The Pension Plan is expected to approach full funding within five years based upon the projected contribution levels and the amendment to freeze the pension plan.

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. In connection with the Pension Plan freeze, Aurora's Board of Directors approved an enhanced match for participants in the Defined Contribution Plans and an additional non-match for all employees to the Defined Contribution Plans beginning in 2013. During 2015, 2014 and 2013, included in salaries, wages and fringe benefits expense is $136.9 million, $128.5 million and $123.8 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 $84.6 million, $77.2 million, and $65.2 million December 31, 2015, 2014 and 2013, respectively, are included in long-term assets whose use is limited or restricted and pension and other employee benefit liabilities, respectively, 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, other agreements relating to its Indebtedness and the Swap Agreement. 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, 2015. Calculations relating to the two financial covenants included in the Master Indenture, Historical Debt Service Coverage Ratio and Days' Cash on Hand, are required to be calculated for Aurora on a consolidated basis, and are presented below:

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

	December 31,		
	2015	**2014**	**2013**
Income Available for Debt Service:			
Excess of revenue over expenses	442,730	539,124	194,959
Depreciation and amortization	198,644	205,798	229,576
Interest expense	57,378	63,602	66,817
	698,752	808,524	491,352
Less Extraordinary or nonrecurring revenue and expense:			
Gain or loss resulting from either the early extinguishment or refinancing of Indebtedness	(543)	—	(1,240)
Gain or loss resulting from pension terminations, settlements or curtailments	(36,848)	—	—
Total extraordinary or nonrecurring revenue and expenses	(37,391)	—	(1,240)
Less unrealized gains or losses:			
Unrealized gains (losses) on investments	(44,170)	2,899	(972)
Less: asset impairment charges	(4,221)	(2,452)	(956)
Total adjustments	(85,782)	447	(3,168)
Income Available for Debt Service	$ 784,534	$ 808,077	$ 494,520
Debt Service Requirements:			
Interest payments due in current year	$ 57,900	$ 64,154	$ 67,532
Principal payments due in current year	58,061	54,633	54,873
Debt Service Requirements	$ 115,961	$ 118,787	$ 122,405
Historical Debt Service Coverage Ratio	6.77	6.80	4.04

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,		
	2015	**2014**	**2013**
Adjusted Cash and Investments			
Cash and cash equivalents	$ 176,626	$ 238,772	$ 310,076
Investments	1,272,107	1,157,604	847,904
Assets whose use is limited – current	10,793	5,560	5,652
Assets whose use is limited - non current	375,551	381,003	369,217
Less: Trustee held funds	(955)	(699)	(32,788)
Less: Donor restricted funds	(54,542)	(56,139)	(52,132)
Less: Other third-party restricted funds	(177,603)	(169,318)	(123,431)
Adjusted Cash and Investments	$ 1,601,977	$ 1,556,783	$ 1,324,498
Days of Operating Expenses			
Operating expenses	4,467,643	4,213,068	4,092,154
Plus: Provision for bad debts	132,805	56,402	221,135
Less: Depreciation and amortization	(198,644)	(205,798)	(229,576)
Adjusted Operating Expenses	$ 4,401,804	$ 4,063,672	$ 4,083,713

	December 31,		
	2015	**2014**	**2013**
Number of days in applicable testing period	365	365	365
Operating Expenses per Day	12,060	11,133	11,188
Days' Cash on Hand	133	142	118

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 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. 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 — 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. 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. Because Aurora does not pursue collection of amounts determined to qualify as charity care under this program, they are not reported as revenue.

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 debt 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 related to 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 (positive 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
John Anderson, M.D.	Senior Vice President Navvis Healthways	2007	2016
Joanne B. Bauer	Retired President Kimberly-Clark Health Care	2013	2016
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	Clinical Professor & Director Densford International Center for Nursing Leadership University of Minnesota School of Nursing	2008	2017
Nan Gardetto	President and Founder The EveryDayGood Foundation	2010	2016
Charles Harvey	Retired Chief Diversity Officer Johnson Controls	2013	2016

Daniel Minahan	President & COO Continental Properties, Co., Inc.	2007	2016
Chris L. Shimojima	Founder, The Pocket Suite, LLC Former CEO, Provide Commerce Inc.	2015	2018
Tim Sullivan	CEO REV Group, Inc.	2010	2016
Nick Turkal, M.D.	President and CEO Aurora Health Care, Inc.	2006	Ex Officio
Rick Weiss	Retired Partner Foley & Lardner LLP	2010	2016
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 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 of 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 Committee. The Audit 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 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 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 Committee is also responsible for reviewing actions taken to address IT cybersecurity.

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 which, among other things, includes population health and consumerism initiatives, 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 a partner with 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 Issuer.

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 Committee are compensated for their time spent attending and preparing for Audit 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, M.D., age 48, Executive Vice President and Chief Medical Officer. Dr. Anderson, MD, 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 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 degree in business administration from Marquette University.

Stephen E. Bablitch, J.D., age 62, Chief of Strategic Business Affairs. Mr. Bablitch joined Aurora in March of 2009. Prior to joining Aurora, Mr. Bablitch was a partner in the law firm of Quarles & Brady, a 450 attorney Milwaukee-based law firm. Mr. Bablitch also served as the former CEO and Chairman of the Board of Directors of Blue Cross & Blue Shield of Wisconsin/Cobalt Corporation. He also served in former Wisconsin Governor Jim Doyle's cabinet as Secretary of the Department of Administration and was responsible for overseeing the state budget, finance, building program, information technology and procurement. Mr. Bablitch also served in the cabinet of former Wisconsin Governor Tommy Thompson and had a career in the private practice of law and as a prosecutor. In addition, he serves on numerous boards for the community. He is a graduate of the University of Wisconsin - Madison Law School and earned a Bachelor of Arts Degree from the University of Wisconsin - Madison graduating with Distinction.

Jeffrey W. Bailet, M.D., age 60, Executive Vice President of Aurora Health Care and President of Aurora Medical Group. Dr. Bailet is a practicing Otolaryngologist-Head & Neck Surgeon. He joined Aurora in 2003 when he was appointed to a newly created Aurora Medical Group regional position established to provide local physician leadership to 120 multi-specialty physicians located in 16 clinics throughout southeastern Wisconsin. He was appointed to the position of President of Aurora Medical Group in

January 2006. Dr. Bailet received his M.D. in 1987 from the University of Washington, and completed his internship and residency at the University of California, Los Angeles from 1987 to 1993. He is a Diplomat of the American Board of Otolaryngology, a Fellow of the American Board of Otolaryngology, and a Fellow of the American College of Surgeons. Prior to joining Aurora, Dr. Bailet practiced medicine in Seattle, Washington. In 2000, he founded a multi-specialty group practice in the Seattle area, and served as its President. At the same time he served as Chief Executive Officer of Associated Healthcare Consultants, a physician-formed consulting group created to bring payers and providers together using new financial arrangements and innovative technology solutions.

Jeff Bard, age 48, Executive Vice President of Aurora Health Care – North Region. Mr. Bard is responsible for providing operational and strategic leadership for clinic, hospital and Aurora at Home operations for the North Region. He is responsible for driving clinical and service excellence, caregiver and physician engagement, strategic growth, and financial performance. Prior to joining Aurora in August 2007, Mr. Bard was Director of Clinic Operations at ProHealth Care in Waukesha, Wisconsin, overseeing daily operations for over 100 primary and specialty care physicians. He earned a Master's Degree in Healthcare Administration and a Master's Degree of Business Administration at the University of Minnesota.

Michael Brophy, age 57, Chief of Staff and Chief Communications Officer. Mr. Brophy is responsible for reputation management, media relations, marketing and advertising, employee communications, web/digital and social media, stakeholder relations, as well as Chief of Staff to Dr. Nick Turkal. Prior to joining Aurora in 2009, Mr. Brophy served as Vice President-Communications and primary spokesman for Milwaukee-based Midwest Airlines for two years prior to its sale by TPG Capital to Republic Airlines and was responsible for managing all media relations, employee communications, government affairs and community outreach. In addition, he serves on the boards of directors for a number of Milwaukee-based and statewide nonprofit organizations. Mr. Brophy is a graduate of the University of Wisconsin – Madison.

Gerard Colman, PhD., age 46, Chief Operating Officer. Dr. Colman joined Aurora in February 2014. Prior to joining Aurora, Dr. Colman was the Senior Vice President and Chief of Clinical Operations at The University of Texas MD Anderson Cancer Center in Houston, Texas. He was responsible for hospital and clinic operations, ancillary services, and several off-campus care operations, as well as the strategic revenue and annual budget process and the coordination of research funding as it related to hospital operations. Prior to joining MD Anderson in 2004, Dr. Colman was employed by Newark Beth Israel Medical Center, Irvington Hospital, and the Children's Hospital of New Jersey. He served as Administrative Director of Patient Care Operations & Financial Services. Dr. Colman began his career in healthcare in the United States Navy. Dr. Colman received his PhD from The University of Texas School of Public Health; he has his Masters in Healthcare Administration from the School of Social Research in New York, and his Bachelors in Healthcare Administration from Southern Illinois University.

Patrick Falvey, PhD., age 51, Executive Vice President of Integration Shared Services. Dr. Falvey has worked at Aurora since 1992 in leadership roles for productivity, quality, care management, strategy, and research. Currently, Dr. Falvey works in partnership with Aurora's clinical leadership to direct Aurora's Patient experience for clinical and service quality. He leads decision support, strategic planning, and

project management. His responsibilities also include operations improvement/productivity, lean/six sigma, knowledge management, and clinical registries. Dr. Falvey received his bachelor's degree in pre-medicine studies from the University of Wisconsin-Whitewater; his masters of science degree in industrial organizational psychology from the University of Wisconsin-Oshkosh; and his doctorate degree in urban studies with an emphasis on organizational psychology/sociology from the University of Wisconsin-Milwaukee.

Cristy Garcia-Thomas, age 47, Chief Diversity Officer and President of Aurora Health Care Foundation. Ms. Garcia-Thomas joined Aurora as President of Aurora Health Care Foundation in September 2011. Previously Ms. Garcia-Thomas led the United Performing Arts Fund (UPAF) as President for four years. Her role at UPAF included oversight of all operational aspects of the organization, including strategic planning, revenue growth, fundraising, marketing, community relationships, and general management functions. UPAF is the largest united arts fund in the country for the performing arts. Ms. Garcia-Thomas brings to Aurora an extensive history in the business community, serving in a variety of roles at the Milwaukee Journal Sentinel. She also serves on a number of community boards of directors. Ms. Garcia-Thomas completed the Advanced Executive Program at Northwestern University in 2003 and earned her B.A. in Journalism and Mass Communications from Kansas State University in 1992.

Gail L. Hanson, age 60, Chief Financial Officer. Ms. Hanson is responsible for financial reporting, billing, budgeting, capital planning, investment and treasury functions. Prior to joining Aurora in February 2011, Ms. Hanson was Deputy Executive Director for the State of Wisconsin Investment Board, where she provided oversight of asset investments for the pension plan, including establishing compliance policies and participating in corporate government. Ms. Hanson previously worked at Blue Cross & Blue Shield United of Wisconsin/Cobalt Corporation. There she held a variety of positions, including Senior Vice President, Treasurer, and Chief Financial Officer. She was an auditor with Price Waterhouse (now PwC) earlier in her career. Ms. Hanson earned her bachelors of business administration degree from the University of Michigan and her masters of business administration degree from the Booth School of Business at the University of Chicago. Ms. Hanson is a certified public accountant and a chartered financial analyst.

Shelly Hart, age 52, Senior Vice President and General Counsel. Ms. Hart joined Aurora in 2010 as Deputy General Counsel and became General Counsel in 2013. She is responsible for managing the legal department and overseeing all legal matters for Aurora. Prior to joining Aurora, Ms. Hart 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. Ms. Hart serves on a number of community Boards. Ms. Hart received her law degree and her bachelor's degree from the University of Wisconsin-Madison.

MaryBeth Kingston, age 60, Executive Vice President and Chief Nursing Officer. Ms. Kingston joined Aurora in June 2012. Ms. Kingston co-leads the strategy for integrated services, and provides strategic direction for nursing, clinical education, chief nurse executives and the eICU. Ms. Kingston is also responsible for developing nursing leadership, as well as advancing the professional practice of nursing and leading system nursing shared governance. Prior to joining Aurora, Ms. Kingston was vice president and chief nurse executive at Einstein Healthcare Network in Philadelphia, a network that includes a 502-

bed acute and tertiary care medical center, 234-bed tertiary rehabilitation center and 80-bed community hospital, as well as a long-term care facility, behavioral health system, restorative care facility, ambulatory care center and a physician practice network. Ms. Kingston is a registered nurse and Nurse Executive Advanced-Board Certified. She received her masters of science in nursing from the University of Pennsylvania and her undergraduate degree from West Chester University in West Chester, Pennsylvania. Ms. Kingston is currently enrolled in a doctoral program at the University of the Sciences in Philadelphia.

Rick Klein, age 58, Executive Vice President of Enterprise Business Group. Mr. Klein is responsible for the five-year business plan for Aurora. He is also responsible for managed care strategy, growth, strategic alliances, mergers and affiliations and AACN. In addition, he is responsible for market strategy and the analytics function system wide. Previously at Aurora, he was the Senior Vice President of Business Development, the Vice President of Growth and Market Development and the Vice President of Marketing. Prior to Aurora, Mr. Klein was the Vice President of Marketing at Wisconsin's largest bank, and was the Vice President of Strategy at MGIC. He earned his masters of business administration degree from Northwestern University J.L. Kellogg School of Business and has an undergraduate degree from Georgetown University.

Mike Lappin, age 50, Chief Administrative Officer, Corporate Secretary. Mr. Lappin joined Aurora in 2009 as Vice President and General Counsel. He was appointed to the position of Chief of Corporate Services and Legal Affairs in June of 2013 and then to Chief Administrative Officer, Corporate Secretary in December of 2013. Prior to joining Aurora, Mr. Lappin was a partner at Quarles & Brady where he served for several years as the Chair of the firm's Corporate Services Practice Group and on the firm's management committee. Mr. Lappin serves on a number of community boards. He received his J.D. and Masters of Public Administration from the University of Wisconsin – Madison and earned a B.A. from Duke University.

Eugene W. Monroe, M.D., age 69, Executive Vice President of Aurora Health Care and President of Aurora Health Care Medical Group. Dr. Monroe is co-President of Aurora's medical group responsible for integration and operations, as well as, system clinical program development. Previously, Mr. Monroe served as President of Aurora Advanced, a multispecialty group practice comprising approximately 290 physicians, operating fourteen clinics in the greater Milwaukee area. Dr. Monroe has also served as the President of Milwaukee Medical Clinic and Advanced Healthcare, the predecessor clinics to Aurora Advanced, since 1980. Dr. Monroe received his B.A. in Economics in 1968 and his M.D. in 1972 from the University of Michigan. He completed his residency training in dermatology at the University of Michigan in 1976. He practiced dermatology at Milwaukee Medical Clinic and Advanced Healthcare for over 25 years. Dr. Monroe has published many articles and presented at numerous national and international medical meetings. He is a member of the American Academy of Dermatology and the American College of Physician Executives.

Dennis Potts, age 61, Executive Vice President of Aurora Health Care – South Region. Mr. Potts is responsible for providing both operational and strategic leadership for the hospital and clinic facilities within the South Region. Previously, Mr. Potts served as senior vice president of corporate services for Aurora where he had direct oversight for all Aurora real estate functions, including leasing, property acquisition, construction and maintenance of properties. Prior to that, he was regional vice president of

Aurora's metro region and in charge of the Aurora Visiting Nurse Association. Mr. Potts received his master's degree in business administration from the University of Wisconsin – Milwaukee. He completed his B.S. in business administration in 1994 from Cardinal Stritch University. In addition, Mr. Potts serves on a number of community boards.

Amy Rislov, age 46, Chief Human Resources Officer. Ms. Rislov is responsible for Total Rewards (benefits and compensation), talent acquisition, employee and labor relations, organizational development and education, loss prevention, executive and leadership development, and talent management. Ms. Rislov has served as Chief Human Resources Officer since April 2014 and, prior to that, she served as Senior Vice President Human Resources Services for Aurora. Ms. Rislov received her Masters of Science in Management in 2011 from Cardinal Stritch University in Milwaukee, WI. She completed her Bachelor of Science in History in 1992 from the University of Wisconsin, Madison, Wisconsin. Ms. Rislov has over twenty years of experience in management and human resources operations.

Preston Simons, age 57, Chief Information Officer. Mr. Simons joined Aurora in 2015 as Chief Information Officer. Prior to Aurora, Mr. Simons held the position of CIO at Abbott Laboratories, a Fortune 100 medical device on safe science company. He previously served as an 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. Mr. Simons has affiliations with many health care IT professional organizations. He 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. Mr. Simons holds a bachelor's degree in business administration from the Illinois Institute of Technology and his masters in business administration degree from the Booth School of Business at the University of Chicago.

Nick W. Turkal, M.D., age 60, President & Chief Executive Officer. Dr. Turkal affiliated with Aurora in 1990 and has served as CEO since 2006. Dr. Turkal received his M.D. in 1982 from Creighton University in Omaha, Nebraska. He completed his Family Medicine Residency in 1985 at St. Michael Hospital, Milwaukee, Wisconsin. He has practiced Family Medicine and Geriatrics in both rural and urban settings. He received his administrative training through the American College of Physician Executives and Kellogg School of Management, and has held administrative positions for over 20 years. As a member of the faculty of the University of Wisconsin Medical School, Dr. Turkal served as residency director, department chair, and as Senior Associate Dean for the Milwaukee Clinical Campus of the University of Wisconsin Medical School. Within Aurora, he has served as Vice President for Academic Affairs, Vice President of Care Management & Quality, Senior Clinical Vice President/Chief Medical Officer and Metro Region President. He is a member of the American Medical Association, American Academy of Family Physicians, and the American College of Physician Executives.

EXHIBIT 1

RISK FACTORS

The following is a discussion of certain risks that may adversely affect Aurora's operations and financial condition. It is not exhaustive, and should be read in conjunction with all other parts of this Annual Report and the audited financial statements of Aurora for calendar years ended December 31, 2015 and 2014, which can be found at emma msrb.org.

For purposes of this Exhibit 1, the defined term "*Aurora*" includes Aurora Health Care, Inc. and its affiliates and subsidiaries. The entities that comprise Aurora are individually referred to as an "*Aurora System Entity*".

Impact of National and Global Economies and Disruptions of Credit Markets

Stress and volatility in the national and global economies have had, and may continue to have, negative repercussions upon the U.S. economy, including a scarcity of credit, lack of confidence in the financial sector, extreme volatility in the financial markets, increase in interest rates, reduced business activity, increased consumer bankruptcies and increased business failures and bankruptcies.

The current economic climate has adversely affected the health care sector generally. Patient service revenues and inpatient volumes have not increased as historic trends would otherwise indicate. Until recently, unemployment rates were increasing nationally, which has resulted in increased self-pay admissions, increased levels of bad debt and uncompensated care, reduced demand for elective procedures, and reduced availability and affordability of health insurance. The economic climate is also increasing stresses on state budgets, potentially resulting in reductions in Medicaid payment rates and tightening of Medicaid eligibility standards, and delays of payment of amounts due under Medicaid and other state or local payment programs.

Risks related to Investments

Aurora has significant holdings in a broad range of investments. Market fluctuations have affected and will continue to materially affect the value of those investments and those fluctuations may be and historically have been material. Global and national market disruptions have exacerbated the market fluctuations and negatively affected over certain time periods the investment performance of securities in Aurora's portfolios. Investment income (including both realized and unrealized gains on investments) has contributed significantly to Aurora's financial results over recent years and, as such, future market fluctuations may negatively affect the financial condition and operations of Aurora as a whole.

Risks Related to Variable Rate Obligations

Increased Interest Rates. Aurora is subject to interest rate risk with respect to the variable rate debt of certain Aurora System Entities. Variable rates may be volatile and can rise or lower based on multiple factors, including general market conditions and the financial strength of Aurora and any related credit or liquidity provider. Aurora's ability to mitigate interest rate risk by refunding or converting such variable rate debt to bear interest at a longer term mode could be further limited by market conditions. Increased interest cost may materially adversely affect the financial condition and operations of Aurora as a whole.

Liquidity Risk. Certain Aurora System Entities have entered into liquidity agreements to provide funding for its repurchase obligations with respect to its variable rate debt. No assurance can be given that such liquidity agreements will be extended or renewed or that Aurora will be able to obtain alternate liquidity or credit facilities for such debt. Any failure to renew a liquidity or credit facility would result in a mandatory tender for purchase of the related variable rate debt, which, if not remarketed, would amortize more quickly than its original stated amortization schedule and bear interest during that amortization period at an interest rate that is likely to be significantly higher than the interest rate which would otherwise apply to such debt. Any such rate increase could negatively affect the operations of Aurora taken as a whole.

Aurora has certain outstanding debt that is in a long-term mode and not secured by a liquidity facility. In addition, Aurora may incur in the future additional debt that has no external dedicated liquidity facility. If such debt is tendered or deemed tendered and not remarketed, Aurora would be obligated to purchase such debt from its own funds.

Aurora's ability to provide self-liquidity for such bonds may be adversely impacted by a variety of factors, including a reduction in investment income and a lack of availability of external liquidity from revolving or other credit facilities.

See "ANALYSIS OF FINANCIAL CONDITION - Indebtedness" in the Annual Report for a description of Aurora's debt obligations.

Banking and Bond Insurance Industry Risk

Disruption and declines in the financial markets had a severe, adverse effect on the financial condition of a number of bond insurers and financial institutions, weakening their financial condition and, in some instances, resulting in bankruptcies of financial institutions and insurers. A weakening of the financial condition of the financial institutions and insurer that provide credit and liquidity support for certain of Aurora's variable rate debt, including any resulting rating downgrade or adverse rating action, may result in higher interest cost to Aurora.

See "ANALYSIS OF FINANCIAL CONDITION - Indebtedness" in the Annual Report for a description of Aurora's existing liquidity and credit support providers.

Proposed Changes to Tax Treatment of Tax-Exempt Bonds

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. Certain of these proposals arose in connection with the discussions in Congress related to the "fiscal cliff" and may arise in connection with future discussions regarding the federal budget and the debt ceiling.

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.

Interest Rate Swap and Other Hedge Risks

Certain Aurora System Entities have and may periodically enter into interest rate swap agreements. Changes in the market value of such agreements could negatively or positively impact Aurora's operating results and financial condition, and such impact could be material. Any interest rate swap or other hedge agreement to which a member of Aurora is a party may, at any time, have a negative value to Aurora. If either a swap or other hedge counterparty or a member of Aurora terminates such an agreement when the agreement has a negative value to Aurora, the member of Aurora would generally be obligated to make a termination payment to the counterparty in the amount of such negative value, and such payment could be substantial and potentially materially adverse to Aurora's financial condition as a whole. Aurora currently has one outstanding total return swap transaction outstanding in a notional amount equal to $83.7 million at December 31, 2015. See "ANALYSIS OF FINANCIAL CONDITION - Interest Rate Swap Agreement" in the Annual Report.

Health Care Reform Law

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the *"Health Care Reform Law"*) are designed to overhaul the United States health care system and regulate many aspects of and players in the health care arena, including individuals, employers and health insurers. This legislation addresses almost all aspects of hospital and provider operations and health care delivery, and has changed and will continue to change how health care services are covered, delivered, and reimbursed. These changes will result in lower reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for health care providers to assess, and potentially alter, their business strategy and practices, among other consequences. While most providers will receive reduced payments for care, millions of previously uninsured Americans may have coverage. Requirements for state health information exchanges could fundamentally alter the health insurance market and negatively impact providers by taking on a rate-setting role. Federal

deficit reduction efforts will likely curb federal Medicare and Medicaid spending further to the detriment of hospitals, physicians, and other health care providers.

On June 28, 2012, the U.S. Supreme Court upheld most provisions of the Health Care Reform Law, including the requirement that individuals maintain health insurance coverage. The Supreme Court also ruled that the federal government could not compel states to comply with the Health Care Reform Law's requirement to expand Medicaid by eliminating all federal funds a state receives for its existing Medicaid program. Since the Supreme Court's decision was handed down, attempts to proceed with legislation to repeal or amend provisions of the Health Care Reform Law have continued. At this time, it is not possible to predict the outcome of legislative attempts to repeal or amend the Health Care Reform Law or other potential legislative efforts aimed at incentivizing a state's expansion of its Medicaid program. The Health Care Reform Law is still subject to legal challenges, the most recent decision being the U.S. Supreme Court case of King v. Burwell, which upheld, as consistent with the Health Care Reform Law, the outlay of premium tax credits to qualifying persons in all states, both those with exchanges established directly by a state, and those otherwise established by the Department of Health and Human Services.

A significant component of the Health Care Reform Law is the expansion of the base of health care consumers through the reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents of their employees. One of the primary drivers of the Health Care Reform Law is to provide, make available, or subsidize the premium costs of health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. The Health Care Reform Law proposed to accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as "health insurance exchanges") in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents of their employees; (ii) providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels; (iii) mandating that individual consumers obtain and certain employers provide a minimum level of health care insurance or face penalties or taxes for noncompliance with such mandates; (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps; and (v) expansion of existing public programs, including Medicaid for individuals and families. The Congressional Budget Office ("*CBO*") estimates that insurance coverage provisions of the Health Care Reform Law will increase the number of non-elderly people who have health insurance by about 20 million in 2015, and 11 million in 2016. To the extent all or any of the Health Care Reform Law provisions produce the intended result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues, and a risk of physician shortages, especially in specialties necessary to provide critical intervention or chronic disease management (*e.g.*, primary care).

High-deductible insurance plans have become more common in the last several years, and the Health Care Reform Law is expected to encourage the increase in such plans, as the health insurance exchanges offer plans that afford a lower monthly premium in return for a higher deductible. High-deductible plans may result in lower inpatient volumes as patients choose less expensive medical treatment to escape costs associated with high deductibles. Alternatively, some patients without the ability to pay their portion of the medical bills insured under the high-deductible plans could result in an increase in bad debt expenses.

The Health Care Reform Law also contains a number of sections related to health care fraud and abuse and program integrity as well as significant amendments to existing criminal, civil and administrative anti-fraud statutes. See "Regulatory Matters" below. Increased compliance and regulatory requirements, disclosure and transparency obligations, quality of care expectations and extraordinary enforcement provisions that could greatly increase potential legal exposure are all aspects of the Health Care Reform Law that could increase operating expenses to Aurora.

The Health Care Reform Law has expanded access to Medicaid and the scope of services thereunder, as Medicaid is expected to cover all individuals with incomes of less than 138% of the federal poverty level (133% plus a statutory 5% income disregard). Beginning in 2014, the law allowed states to expand Medicaid eligibility to elderly, non-pregnant individuals with incomes of less than 138% of the federal poverty level. The federal government is

expected to pay 100% of the new cost of expansion for a limited number of years. However, the decision to expand Medicaid is a decision left to the states. The State of Wisconsin has decided not to expand its Medicaid program to cover said individuals and thus has declined the additional federal matching funds that would result from such expansion.

With respect to charity care, the Health Care Reform Law contains many features from previous tax exemption reform proposals, including a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Internal Revenue Code. The Health Care Reform Law: (a) imposes new eligibility requirements for 501(c)(3) hospitals, coupled with an excise tax for failures to meet certain of those requirements; (b) requires mandatory IRS review of the hospitals' entitlement to exemption; (c) sets forth new reporting requirements including information related to community health needs assessments and audited financial statements; and (d) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels. See "Maintenance of the Tax-Exempt Status of Aurora" below.

Some provisions of the Health Care Reform Law are currently effective while others are being phased in over periods of up to ten years. Given the general complexity of the Health Care Reform Law, additional legislation is likely to be considered and enacted over time. The Health Care Reform Law will also require the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors as well as suppliers and vendors of goods and services to health care providers are expected to impose new contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements as well as contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

Health Care Payment Reform. As a part of the Health Care Reform Law described above, the payment structure from payors, including Medicare, Medicaid and other government programs, as well as from private payors, may be altered from current methodologies. With varying effective dates, the annual Medicare market basket updates for many providers, including hospitals, will be reduced, and adjustments to payments for expected productivity gains will be implemented. The Health Care Reform Law also provides for the implementation of various demonstration projects and pilot projects to test, evaluate, encourage, and expand existing and new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care. Such projects include bundled payments under Medicare and Medicaid, and comparative effectiveness research programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Certain other provisions of the Health Care Reform Law encourage the creation of new health care delivery programs, such as accountable care organizations in which a group of providers is held jointly responsible for improving the quality and cost of health care of a certain population, with the opportunity to share in any financial benefits that result or combinations of provider organizations, that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted. The effect of any type of reform is uncertain and may reduce Aurora's net revenue.

Scrutiny of Nonprofit Tax-Exempt Organizations

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. These challenges and questions have come from a variety of sources, including the Attorney General office of a particular state, the Internal Revenue Service (the *"IRS"*), labor unions, Congress, state

legislatures, other federal and state agencies and patients, and in a variety of forums, including hearings, audits and litigation. Certain of these challenges are discussed in more detail below.

Internal Revenue Service Form 990. The Internal Revenue Service Form 990 is used by 501(c)(3) not-for-profit organizations to submit information required by the federal government for tax-exemption. Form 990 requires detailed public disclosure of compensation practices, corporate governance, loans to management and others, joint ventures and other types of transactions, political campaign activities and other areas the IRS deems to be compliance risk areas. Form 990 also requires the reporting of detailed community benefit information and establishes uniform standards for the reporting of charity care. Form 990 also contains a separate schedule requiring detailed reporting of information relating to tax exempt bonds, including compliance with the arbitrage rules and rules limiting private use of bond-financed facilities, including compliance with the safe harbor guidance in connection with management contracts and research contracts. Form 990 allows for enhanced transparency as to the operations of exempt organizations. It is likely to result in enhanced enforcement, as Form 990 makes available a wealth of detailed information on compliance risk areas to the IRS and other stakeholders, including state attorneys general, unions, plaintiff's class action attorneys, public watchdog groups and others. The Health Care Reform Law amended the Code to require tax-exempt hospitals to include in their Form 990 a report describing how they are addressing the needs identified in each community health needs assessment conducted as required under the Health Care Reform Law (see "Maintenance of the Tax-Exempt Status of Aurora" below) and their audited financial statements (or the consolidated financial statements in which they are included). The IRS has begun to audit tax exempt bonds based on information on the Form 990.

Litigation Relating to Billing and Collection Practices. Lawsuits have been filed in both federal and state courts alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. The cases are proceeding in various courts around the country with inconsistent results. While it is not possible to make general predictions, some hospitals and health systems have incurred substantial costs in defending such lawsuits, and in some cases have entered into substantial settlements. No Aurora System Entity is currently a defendant in a lawsuit alleging it has overcharged uninsured patients.

Challenges to Real Property Tax Exemptions. Recently, the 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. As a result, while management of Aurora is not aware of any current challenges to the tax exemption afforded to any of its material real property, there can be no assurance that such challenges will not occur in the future.

Action by Purchasers of Hospital Services and Consumers. Major purchasers of hospital services could take action to restrict hospital charges or charge increases. As a result of increased public scrutiny, it is also possible that the pricing strategies of hospitals may be perceived negatively by consumers, and hospitals may be forced to reduce fees for their services. Decreased utilization could result, and hospitals' revenues may be negatively impacted. In addition, consumers and groups lobbying on behalf of consumers are increasing pressure for hospitals and other health care providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive health care services.

Patient Service Revenues

Medicare and Medicaid Programs. Medicare and Medicaid are the commonly used names for hospital reimbursement or payment programs governed by certain provisions of the federal Social Security Act. Medicare is an exclusively federal program and Medicaid is jointly funded by federal and state government and governed by both

federal and state laws. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older or disabled, or qualify for the End Stage Renal Disease Program. Medicaid is designed to pay providers for care given to the medically indigent, is funded by federal and state appropriations, and is administered by the individual states. Federal funding is provided to a state for its Medicaid program in the form of matching payments in amounts equal to a percentage of state Medicaid expenditures, ranging from 50% to 100%, depending upon the use of the funds and the per capita income of the state recipient. These federal medical assistance percentages ("*FMAPs*") are recalculated for each federal fiscal year. Receipt of federal funding is contingent on a state Medicaid program's compliance with federal standards regarding beneficiary eligibility, coverage, benefits, and use of FMAP payments. A number of provisions of the Health Care Reform Law impact FMAPs (e.g., FMAPs of up to 100% for certain newly eligible individuals, increased FMAPs for disaster-affected states, primary care payment rate increases, specific preventative services and immunizations, smoking cessation for pregnant women, and health home services for patients with certain chronic conditions). Hospital benefits are available under each participating state's Medicaid program, within prescribed limits, to persons meeting certain minimum income or other eligibility requirements, including children, the aged, the blind and/or disabled.

Health care providers have been and will continue to be significantly impacted by changes in the last several years to the federal health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs. The Health Care Reform Law amended Medicaid funding and substantially increased the potential number of Medicaid beneficiaries. In June 2012, the Supreme Court ruled that states could decline to expand Medicaid coverage without losing their existing federal funding for the program. Certain outcomes, such as a state refusing to expand Medicaid coverage, which brings more patients to most hospital providers, while Medicaid payment cuts are implemented, could put providers at greater risk. With respect to Medicare, the Health Care Reform Law, among other things, mandates significant reimbursement modifications, such as moving from a fee-for-service model to a quality of care model where value-based payments are tied to certain clinical objectives, including, but not limited to, patient outcomes and patient satisfaction.

Past federal budgets have contained cuts to the Medicare and Medicaid program budgets. In addition, due to the sequestration required by the Budget Control Act of 2011 (the "BCA"), cuts to the Medicare program of 2% of total program costs began on April 1, 2013. Such sequestration for Medicare and other programs was extended through 2023 by the Bipartisan Budget Act of 2013, which was signed into law in December 2013. Because Congress may make changes to the budget in the future, it is impossible to predict the impact these and any additional spending cuts may have upon Aurora. Reductions in Medicare and/or Medicaid spending may have a material adverse effect upon the financial condition of Aurora. While it is uncertain whether future federal budgets will propose additional cuts to these programs, any reduction in the level of Medicare and/or Medicaid spending or a reduction in the rate of increase of Medicare and/or Medicaid spending may have an adverse impact on the revenues of Aurora derived from the Medicare and Medicaid programs.

On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015 (the "2015 BBA"), which increased the budget caps imposed by the BCA for fiscal years 2015 and 2017 and authorized $80 billion in increased spending over the next two years. The 2015 BBA also suspended the limit on the federal government's debt until March 2017.

The following is a summary of the Medicare and Medicaid programs and certain risk factors related thereto.

Medicare

Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS' "Conditions of Participation" on an ongoing basis, as surveyed by the CMS delegated agency in the state in which the provider is located, or an accreditation organization such as The Joint Commission, DNV Healthcare Inc. or the American Osteopathic Association. The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, personnel, billing, policies

and services. CMS may determine that a provider is not in compliance with its Conditions of Participation. In that event, a notice of termination of participation in Medicare may be issued or other sanctions potentially could be imposed.

Components of the Recovery Act (defined below) provide for Medicare incentive payments beginning in 2011 to hospital providers meeting designated deadlines for the installation and use of electronic health information systems. For those hospital providers failing to meet a 2016 deadline, Medicare payments will be significantly reduced. It is not clear what effect, if any, this legislation will have on revenues of Aurora. For the year ended December 31, 2015, 27% of Aurora's patient service revenue, net of contractual allowances and discounts (before the provision for bad debts) was derived from the Medicare program. Any revisions to the Medicare program or to Aurora affiliates' classification under the Medicare program may significantly affect Aurora's revenues. The laws and regulations governing Medicare reimbursement are extremely complex and subject to interpretation. In addition, there is no guarantee that the reimbursement methodologies described below for Medicare inpatient and outpatient services will continue in their present format, since those methodologies and the associated payment rates have been the frequent subject of Congressional action.

In addition, there is no assurance that Aurora will be paid amounts that will reflect adequately their operating costs incurred in providing inpatient hospital services to Medicare beneficiaries, as well as any changes in the cost of providing health care or in the cost of health care technology being made available to Medicare beneficiaries.

Hospital Inpatient Reimbursement. Hospitals are generally paid for inpatient services provided to Medicare beneficiaries through an inpatient prospective payment system ("*IPPS*") that established rates based on categories of treatments or conditions known as Medicare-severity diagnosis related groups ("*MS-DRGs*") and is adjusted annually through the market basket update, a factor that measures the inflation experienced by hospitals in purchasing the goods and services necessary to provide inpatient services. DRGs are a system of classifying inpatient hospital services based on a person's medical diagnosis, any secondary diagnoses, surgical procedures, age, sex and presence of any complications. Payments are made to hospitals based on the DRG assignment for each patient's diagnosis. Hospital reimbursement will be set at specific rates established by Medicare for that particular patient's DRG, regardless of the actual costs incurred by the hospital for such treatment. CMS established a new DRG classification system in its 2008 IPPS Final Rule, which categorizes base DRGs by severity and weight. The actual cost of care, including capital costs, may be more or less than the DRG rate. DRG rates are subject to adjustment by CMS and are subject to federal budget considerations. There is no guarantee that DRG rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

CMS continues to revise the IPPS annually. On August 17, 2015, CMS published its 2016 IPPS Final Rule. The 2016 PPS Final Rule includes a negative 0.8% documentation and coding adjustment to recoup overpayments for prior years, and an overall 0.7% net increase in payment rates to acute care hospitals. The Final Rule also updates measures for the Hospital Inpatient Quality Reporting Program and updates measures and incentives for the Hospital Value-Based Purchasing Program. The Final Rule also established a new Hospital-Acquired Condition Reduction Program, which imposes financial penalties on those hospitals that perform the lowest regarding hospital-acquired conditions beginning federal fiscal year 2015. The 2015 PPS Final Rule requires hospitals to make public a list of their standard charges or provide their policies for allowing the public to view a list of those charges in response to an inquiry. Additional recoupment adjustments are planned for federal fiscal year 2017.

Several significant Medicare payment reform measures, designed to incentivize hospitals based on quality and performance measures, have been implemented that include reimbursement incentives and penalties: the Readmission Reduction Program, the Hospital Value-Based Purchasing Program, the Hospital Inpatient Quality Reporting Program and the Hospital-Acquired Condition Reduction Program. The Readmission Reduction Program reduces Medicare payments by specified percentages to hospitals with excess or preventable hospital admissions based on historical discharge data. The Hospital Value-Based Purchasing Program reallocates and redistributes Medicare reimbursement funds to hospitals based on their performance on quality and patient experience measures. For federal fiscal year 2014, the DRG percentage reduction was 1.25% and the percentage reduction will increase by 0.25% each fiscal year until the reduction reaches a maximum of 2.0% for federal fiscal year 2017. Under the Hospital Inpatient Quality Reporting Program, annual payment updates to hospitals that do not meet designated quality measures are reduced by two percentage points, and those that do not successfully meet their targets will lose one-quarter percentage

of the percentage increase in their payment updates beginning in federal fiscal year 2015. Management of Aurora is not aware of any situation in which a Medicare readmission penalty, Hospital Value-Based Purchasing Program performance measure, or payment reduction related to quality reporting is being, or may in the future be, assessed that would materially and adversely affect the financial condition or results of the operations of Aurora taken as a whole.

There can be no assurance that future changes in classifications of patient hospitalizations or revisions to annual documentation and coding adjustments or other payment update measures implemented in future prospective payment regulations will not result in fluctuations or declines in revenue.

Inpatient Capital-Related Costs. Medicare payments for capital costs (e.g., depreciation, interest, taxes and similar expenses for plant and equipment) are based upon a PPS system similar to the inpatient operating cost PPS. A separate per-case standardized amount is paid for capital costs, adjusted to take into account certain hospital characteristics and weighted by DRG. Capital costs are reimbursed exclusively on the basis of a standard federal rate (based upon average national costs of capital), subject to certain adjustments specific to the hospital (such as for disproportionate share, indirect medical education and outlier cases). Effective for discharges occurring after October 1, 2008, the indirect medical education portion of capital costs payments were reduced to half of the amount provided for under the prior formula. The Taxpayer Relief Act is expected to reduce the inpatient prospective payment to hospitals for documentation and coding by $10.5 billion between 2014 and 2018. There can be no assurance that the prospective payment for capital costs will be sufficient to cover the actual capital-related costs of the Aurora allocable to Medicare patient stays or to provide adequate flexibility in meeting Aurora's future capital needs.

Inpatient Hospital Rehabilitation Services. Certain inpatient rehabilitation hospitals and distinct inpatient rehabilitation units of hospitals are reimbursed for inpatient rehabilitation services under a separate Inpatient Rehabilitation Facility PPS (the "*IRF-PPS*"), which was implemented in 2002. The IRF-PPS provides for payment on a per-discharge basis to cover the hospital's operating and capital costs. A classification system groups inpatient rehabilitation patients, who are expected to use similar resources, into a case mix group based on data and diagnostic information collected on each patient following admission, including comorbidity information. The amount of payment under IRF-PPS is based on which case mix groups the patient is assigned.

Hospital Outpatient Reimbursement. Hospitals are generally paid for outpatient services provided to Medicare beneficiaries through an outpatient prospective payment system ("*OPPS*") based on established categories of services known as Ambulatory Payment Classifications ("*APCs*"). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for a patient encounter. Medicare will make additional payment adjustments under OPPS, including (i) "outlier" payments for services where the hospital's cost exceeds 2.5 times the APC rate for that service; and (ii) transitional pass-through payments for certain drugs, biological and medical devices. CMS has proposed to link Medicare payment for outpatient services to the reporting of quality measures. The Outpatient PPS rates are adjusted annually based on the hospital inpatient market basket percentage increase. There can be no assurance that the prospective payment for hospital outpatient services will be sufficient to cover the actual costs of Aurora allocable to outpatient services provided to Medicare beneficiaries. In addition to the APC rate, there is a predetermined beneficiary coinsurance amount for each APC group. There can be no assurance that the beneficiary will pay this amount.

The OPPS Final Rule for calendar year 2011 also implemented several provisions of the Health Care Reform Law which may impact the reimbursement and operations of hospitals across the country. These provisions continue to be implemented by CMS in the 2012 OPPS final rule. Some of the specific reforms addressed in the 2011 OPPS Final Rule and the 2012 OPPS Final Rule that have the potential to impact hospitals are: (i) reduction of the OPPS market basket increase factor by a productivity adjustment (effective 2012) and an additional adjustment for payments to hospital outpatient departments (from 2010 through 2019); (ii) application of similar productivity adjustments for payment for ambulatory surgical center ("*ASC*") services, which began with calendar year 2011; (iii) new provisions relating to the prohibition against referrals to a hospital by a physician who has an ownership or investment interest in the hospital; (iv) adjustments to the area wage adjustment factor for outpatient department services; and (v) changes related to payment for graduate medical education and indirect medical education. Rates and policies set in the OPPS Final Rule for calendar year 2015 will increase payment rates for hospital outpatient departments by 2.2%.

CMS has adopted a policy known as the Inpatient Hospital Prepayment Review "Probe & Educate" review process or the "Two-Midnight" rule. The "Two-Midnight" rule specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. Stays lasting less than two midnights must be treated and billed as outpatient, with certain exceptions. The Two-Midnight rule went into effect on January 1, 2015. It is too early to determine the effect of the implementation of the rule on the Aurora System. However, management does not expect that implementation will have a material adverse effect on the Aurora System.

On October 31, 2015, CMS issued the Medicare OPPS Final Rule for calendar year 2015. As part of the Two Midnight Rule, CMS requires a physician certification, including an admission order and certain additional elements, for all inpatient admissions. The 2015 OPPS Final Rule implemented a change to the requirement that certifications must be provided for all inpatient admissions. Going forward, CMS will require physician certification only for outlier cases and long-stay cases of 20 days or more. An admission order will continue to be required for all inpatients when that patient has been formally admitted to the hospital. The effect of the Two Midnight Rule on Aurora's operations is still unclear, but it may have an adverse financial impact.

The 2015 BBA included significant changes to Medicare provider-based reimbursement that virtually shut down any future off-campus, provider-based site developments and contained legislation that eliminates hospital outpatient perspective payment system ("OPPS") reimbursement as of Jan. 1, 2017, for off-campus facilities that were not billed under the OPPS prior to Nov. 2, 2015. CMS will release its proposed BBA-related guidance in July 2016. Such changes could have an adverse financial impact.

Provider-Based Standards. CMS utilizes an eight-part test to determine whether an entity qualifies as "provider-based" rather than "freestanding." Classification as "provider-based" generally results in a higher level of reimbursement for the same service than if classified as "freestanding." These standards make it more difficult to qualify as provider-based and are aimed at stemming the proliferation of entities characterized as provider-based. If an entity fails to meet the requirements for being classified as "provider-based," such entity may lose such designation resulting in a reclassification to "freestanding." Any such reclassification could significantly reduce reimbursement under the Medicare program.

Medicare Managed Care. Medicare allows Medicare beneficiaries to enroll in Medicare "risk" plans sponsored by health maintenance organizations and provider-sponsored organizations ("*Medicare Risk Plans*") under the Medicare Advantage program. Medicare Risk Plans enter into contractual arrangements with Medicare, pursuant to which the Medicare Risk Plans agree to provide covered services to beneficiaries for a fixed premium amount. The Medicare Risk Plans, in turn, contract with hospitals at negotiated rates, which may be less than standard DRG rates. The Medicare Risk Plans also take measures to control utilization of hospital facilities. In addition to direct utilization controls, the Medical Risk Plans may use compensation methods that are intended to encourage efficient utilization and delivery of services. For example, Medicare Risk Plans may pay providers on a "capitated" basis, that is, at a predetermined amount per enrollee irrespective of the value or intensity of the services used by enrollees. Further, the Medicare Risk Plan contracts may contain a requirement that a hospital care for enrollees for a certain period of time regardless of whether the Medicare Risk Plan has funds to make payment to such hospital. The Health Care Reform Law provides that through September 30, 2019, payments under the Medicare Advantage programs will be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Risk Plans. These beneficiaries may terminate their participation in such Medicare Risk Plans and opt for the traditional Medicare fee-for-service ("*FFS*") program. The reduction in payments to Medicare Risk Plans may also lead to decreased payments to providers by managed care companies operating Medicare Risk Plans. There can be no assurance that the rates negotiated for the treatment of Medicare Advantage enrollees will be sufficient to cover the cost of providing services to such patients. The development of Medicare Risk Plans could have a material adverse effect on the financial condition of Aurora in the future.

In addition, the Taxpayer Relief Act modifies the Medicare Advantage coding intensity adjustment, which adjusts Medicare Advantage payments to account for differences between Medicare and Medicare Advantage.

Other Medicare Service Payments. Medicare payment for skilled nursing services, psychiatric services, inpatient rehabilitation services, general outpatient services and home health services are subject to Medicare's consolidated billing rules. Consolidated billing requires covered providers to bill Medicare for the entire package of services their patients receive, other than a few excluded services, based on regulatory formulas or pre-determined rates. There is no guarantee that these rates, which may fluctuate, will be adequate to cover the actual cost of providing these services to Medicare patients. In addition, there is no assurance that Aurora will be fully reimbursed for all services which each bills through consolidated billing.

Medicare Payment for Preventable Medical Errors. The Deficit Reduction Act of 2005 (the *"DRA"*) required the Secretary of the U.S. Department of Health and Human Services ("*HHS*") to identify complicating conditions present as a secondary diagnosis that are high cost and/or high volume and reasonably preventable through application of evidence-based guidelines (collectively referred to as "hospital-acquired conditions"). The DRA further required hospitals to begin reporting on claims for discharges, beginning October 1, 2007, whether the selected hospital-acquired conditions were present on admission. In its 2008 IPPS Final Rule, CMS included several conditions identified by the National Quality Forum as "never events" (*i.e.*, inexcusable outcomes in a health care setting). Each year, additional conditions classified as hospital-acquired or never events are considered through the inpatient prospective payment system rulemaking process. Most recently, CMS added more conditions in the 2013 IPPS Final Rule. All such conditions have negative payment implications when acquired during an inpatient stay. Effective July 1, 2011, federal payments to states for Medicaid services related to hospital-acquired conditions are prohibited. Commencing in federal fiscal year 2015, Medicare payments to certain hospitals for hospital-acquired conditions such as infections were reduced by one percent. The incidence of adverse events and their payment implications continues to be an area of focus for regulators.

Medical Education Payments. Medicare pays for certain of the direct and indirect costs associated with medical education (including the salaries of residents and teachers and other overhead costs directly attributable to medical education programs). Payment for the direct costs of medical education (*"GME"*) is made on a "pass-through" basis, not PPS, based on a formula that reflects the hospital's base year per-resident costs adjusted by inflation and the number of current-year reimbursable resident positions. Payment for the indirect costs of medical education (*"IME"*) is based on the ratio of a hospital's number of full-time equivalent residents to its number of beds. These payments are vulnerable to reduction or elimination.

Physician Payments. Physicians may elect to "participate" or enroll in the Medicare program as a provider. Medicare Part B provides reimbursement for physician services, including employed and provider-based physicians, based upon a national fee schedule called the Resource-Based Relative Value Scale ("*RBRVS*"). Under the RBRVS system, payments for services are determined by the "resource costs" necessary to provide such services. Payments also are adjusted for geographical differences. The costs have three components: physician work, practice expense and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor. The conversion factor is a monetary amount that currently is determined by CMS's Sustainable Growth Rate ("*SGR*") system.

The SGR system annually takes into account changes in the Medicare FFS enrollment, input prices, spending due to law and regulation, and gross domestic product, effectively changing the RBRVS on an annual basis. SGR targets are compared to actual expenditures in order to determine subsequent physician fee schedule updates. Congress had repeatedly delayed the implementation of the SGR cuts. At the end of March 2015, Congress again postponed the implementation of SGR cuts, which averted an approximate 24.0% reduction to all physician payments reimbursed under fee schedules, which would have been effective April 1, 2015. This last legislative act postponed the implementation of SGR cuts only until March 31, 2015. On April 15, 2015, the Senate passed a bipartisan bill, the Medicare Access and CHIP Reauthorization Act ("*MACRA*"), which repeals the SGR formula. President Obama signed MACRA into law the next day. Under MACRA, physicians are ensured a five year period of stable annual updates of 0.5% increased reimbursement to Medicare payments. Thereafter, MACRA transitions to a new system that moves Medicare towards a value-based system, the Merit-Based Incentive Payment System ("MIPS"). Beginning January 1, 2019, payment will be based on physicians' ability to meet certain performance thresholds in performance categories, including quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. In addition, the MACRA extended CHIP for two additional years through federal fiscal year 2017.

Medicare and Medicaid Audits and Withholds. Hospitals participating in Medicare and Medicaid are subject to audits and retroactive audit adjustments with respect to reimbursement claimed under those programs. Although management of Aurora believes its reserves are adequate for the purpose, any such future adjustments could be material. Both Medicare and Medicaid regulations also provide for withholding payments in certain circumstances. Any such withholding with respect to any Aurora affiliate could have a material adverse effect on the financial condition and results of operations of Aurora. In addition, contracts between hospitals and third-party payors often have contractual audit, setoff and withhold language that may cause substantial, retroactive adjustments. Such contractual adjustments also could have a material adverse effect on the financial condition and results of operations of Aurora. Management of Aurora is not presently aware of any situation in which a Medicare or other payment is being, or may in the future be, withheld that would materially and adversely affect the financial condition or results of operations of Aurora taken as a whole.

Under both Medicare and Medicaid programs, certain health care providers, including hospitals, are required to report certain financial information on a periodic basis, and with respect to certain types of classifications of information, penalties are imposed for inaccurate reports. As these requirements are numerous, technical and complex, there can be no assurance that Aurora will avoid incurring such penalties in the future. These penalties may be material and adverse and could include administrative, criminal or civil liability for making false statements or claims and/or an administrative action for exclusion from participation in the federal health care programs. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act (*"FCA"*) or other federal statutes, subjecting the provider to civil, administrative, or criminal sanctions. The Department of Justice (*"DOJ"*) has initiated a number of national investigations involving proceedings under the FCA relating to alleged improper billing practices by hospitals. These actions have resulted in substantial settlement amounts being paid in certain cases.

Management of Aurora does not anticipate that Medicare audits or cost report settlements for the Medicare program will materially adversely affect the financial condition or results of operations of Aurora, taken as a whole, nor is it aware of any claims that have been improperly submitted by Aurora. However, in light of the complexity of the regulations relating to the Medicare program and the threat of ongoing investigations as described above, there can be no assurance that significant difficulties will not develop in the future.

Recovery Audit Contractors. Section 302 of the Tax Relief and Health Care Act of 2006 required the Secretary of Health and Human Services to utilize recovery audit contractors ("*RACs*") paid on a contingency fee basis under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments under the Medicare program. Beginning April 1, 2013, state Medicaid agencies were also required to implement a recovery audit program to identify underpayments and overpayments. RACs may request to review Medicare and Medicaid payments for services billed during the previous 3 years as well as the current year.

Management of Aurora is not aware of a situation in which a Recovery Audit, if conducted, and any resulting payments made by Aurora would materially adversely affect the financial condition of Aurora. However, in light of the complexity of the regulations relating to the Medicare program and the ongoing threat of audits, there can be no assurance that any audit would not materially adversely affect the financial condition of Aurora.

On February 12, 2016, CMS published the Reporting and Returning of Overpayments Final Rule ("Final Rule"). The Final Rule takes effect on March 14, 2016. The Final Rule provides that, among other things, providers must report and return overpayments within 60 days of the date of identification; and that reasonable diligence to identify overpayments starts with "credible information" that an overpayment may exist and should take no more than six months. Claim or cost report errors that do not result in overpayments are not subject to the Act or the Final Rule. Overpayment determinations, demands or other final actions asserted by a MAC, a RAC, CMS, OIG or other federal agency must follow the existing processes for responding to those determinations. The Final Rule does not change those existing processes.

Medicaid

Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. Pursuant to these broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets the payment rates for services; and administers its own programs. As described under the caption "Nonprofit Health Care Environment - Health Care Reform", one component of the Health Care Reform Law incentivizes states to expand their Medicaid programs to individuals earning up to 138% of the federal poverty level by offering additional Medicaid funding to such states. The State of Wisconsin has decided not to expand its Medicaid programs to cover such individuals and thus has declined the additional federal funding tied to such expansion. Instead, Wisconsin's Medicaid program is limited to individuals earning 100% of the federal poverty level. Beginning on July 1, 2014, individuals above the federal poverty level are no longer eligible for Badger Care Plus, one of Wisconsin's Medicaid programs, and must obtain private insurance through healthcare exchanges. However, childless adults who are below the federal poverty level will be eligible for Badger Care.

For the year ended December 31, 2015, approximately 8% of Aurora's patient service revenue, net of contractual allowances and discounts (before the provision for bad debts) was derived from state Medicaid programs. Management of Aurora cannot predict the effect of the above-described changes to Wisconsin's Medicaid programs on the operations or financial condition of Aurora.

The Wisconsin Department of Health Services is responsible for administering the Wisconsin Medicaid program.

Wisconsin Medicaid payments for inpatient services are based on a DRG system. While the Wisconsin Medicaid DRG system is similar to the Medicare DRG system, certain differences apply. Separate Medicaid base rates are paid for hospitals located in Milwaukee County and those located elsewhere in the state. The base rate is adjusted for a Medicaid DRG factor (different from the Medicare DRG factor) for each patient. As with the Medicare system, there is also an adjustment to the base rate for regional wage differences. There are also adjustments for indirect medical education, disproportionate share hospitals, rural hospitals, and cost outliers. There are additional payments for direct medical education and capital costs. A Wisconsin hospital with a total cost of treating Medicaid patients that exceeds the prospective payment rate will incur a loss on such services.

The Wisconsin Medicaid program has implemented a revised payment methodology for outpatient services effective April 2013. Rather than a per visit rate based on the hospital's costs, payment is made using a system of enhanced ambulatory patient groups ("*EAPG*"). Each EAPG rate is a prospectively determined estimate of resources for outpatient services with discount for multiple procedures during the same visit. The EAPG payment rates are subject to adjustment based on funding amounts.

Hospital Inpatient Reimbursement. For each rate year, July 1 through June 30, the Department updates standard factors used in determining the amount of payment hospitals receive for inpatient hospital services covered by the DRG based payment method. Numerical weights are assigned to each specified DRG and are updated annually to reflect the current, relative resource consumption of each inpatient stay. Weights are determined by an analysis of past services provided by hospitals, claim charges for those services and the relative cost of those services.

Other Medicaid Service Payments. Hospitals are reimbursed for outpatient services at an interim rate per visit with a subsequent retrospective final settlement, which takes into account costs incurred by the hospital during its fiscal year. Reimbursed costs under the settlement are limited to a prospectively established ceiling amount calculated annually for the upcoming State fiscal year effective July 1 based on audited cost reports. Administrative adjustments are available to recognize certain changes in costs that are not reflected in historical cost report periods. Payments for outpatient hospital laboratory tests are limited to the Wisconsin Medicaid Fee Schedule for laboratory tests.

Wisconsin Medicaid also provides reimbursement for extended outpatient nursing services. Hospital outpatient extended nursing services are nursing services and respiratory care provide by nurses, for part of a day in a group

setting, on the site of an approved acute care general hospital, or in a building physically connected to an acute care general hospital.

Payment for Medicaid patients is subject to appropriation by the respective state legislatures of sufficient funds to pay the incurred patient obligations. Most state governments, including Wisconsin, are experiencing considerable budgetary challenges. Many health systems have felt the brunt of these pressures as many states have reduced hospital Medicaid reimbursement rates in order to balance their budgets, creating yet another strain on top-line revenue growth that hospital management must address. Delays in appropriations and state budget deficits which may occur from time to time create a risk that payment for services to Medicaid patients will be withheld or delayed. The Recovery Act provided states with enhanced federal funding that temporarily staved off deeper Medicaid cuts, but the June 30, 2011 expiration date of the enhanced funding may lead to more severe Medicaid reductions.

The federal government continues to explore options for a long-term solution to the funding difficulties with Medicaid. Certain additional proposals being examined may ultimately result in reduced federal Medicaid funding to the states, which could adversely impact the amount of revenue received by Aurora.

Wisconsin requires low income adults and individuals with disabilities who live in select regions and receive social security income to enroll in and receive services from a Medicaid HMO plan. The BadgerCare Plus Section 1115 waiver program and Medicaid SSI Managed Care program offer plans incentive payments, which cannot exceed total capitation revenue by more than 5%. The state withholds 1.5% from each participating managed care organization ("*MCO*"), which can be earned back, based on annual performance related to clinical outcomes, case management, access and availability of services, and member satisfaction. MCOs can also earn a bonus amount on top of the withhold for high ratings on select measures. Plans that are accredited by a nationally recognized body can qualify for an additional Accreditation Incentive payment.

Disproportionate Share Payments. The federal Medicare and state Medicaid laws permit states to include a "disproportionate share" adjustment in payments to hospitals in order to compensate those hospitals that serve a disproportionate share of indigent patients. The Health Care Reform Law reduced disproportionate share payments by 75% as of October 1, 2013, but a portion of the 75% reduction will be distributed back to hospitals based on the percentage of the population that remains uninsured and the amount of uncompensated care provided. These payments will be increased thereafter to account for the national rate of consumers who do not have health insurance and are provided uncompensated care. The Bipartisan Budget Act of 2014 delayed the fiscal year 2015 cuts until fiscal year 2016, but increased the overall level of reductions and extended cuts through fiscal year 2023.

In its 2013-15 state budget plan, the Wisconsin legislature expanded payments to hospitals that serve a disproportionate share of low-income patients. A hospital will receive financial assistance if its low-income inpatient days account for more than six percent of the hospital's total inpatient days. The hospital payment is proportional to the percentage of low-income patients that the hospital treats. In its 2015-2017, state budget plan, the Wisconsin legislature added over $30 million to provide supplemental payments to disproportionate share hospitals.

340B Drug Pricing Program. Aurora participates in the 340B Drug Pricing Program (the "*340B Program*"), a federal program that requires drug manufacturers participating in the Medicaid drug rebate program to provide outpatient drugs to enrolled "covered entities" at or below the statutorily-defined ceiling price. In November 2014, the Office of Pharmacy Affairs, which is the federal agency under HRSA that regulates the 340B Program, announced its withdrawal of an extensive proposed rule, indicating it would instead issue informal guidance and a series of proposed rules on smaller subsets of topics within the 340B Program over the next year. Restrictions on the ability of hospitals to utilize 340B Program drugs for their patients may have an adverse effect on any Aurora entity participating in this program.

Health Plans and Managed Care. Aurora's ability to develop and expand its services and, therefore, profitability, is dependent upon their ability to enter into contracts with third-party payors at competitive rates. However, the current economic climate has resulted in lower rate increases from commercial healthcare insurers. There can be no assurance that they will be able to attract third-party payors, and where they do, no assurance can be given that they will be able to contract with such payors on advantageous terms. The inability of Aurora to contract with a sufficient

number of such payors on advantageous terms could have a material adverse effect on Aurora's future operations and financial results.

The Health Care Reform Law imposes, over time, increased regulation of the industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments by some consumers and employers and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the Health Care Reform Law imposes many new obligations on states related to health care insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect Aurora. The effects of these changes on the financial condition of any third-party payor that offers health care insurance, the rates paid by third-party payors to providers such as Aurora, and upon the operations and financial condition of Aurora cannot be predicted.

Many preferred provider organizations, or PPOs, and health maintenance organizations, or HMOs, currently pay providers on a negotiated fee-for-service basis or on a fixed rate per day of care, which, in each case, usually is discounted from the typical charges for the care provided. The discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a hospital may vary significantly from projections, and/or changes in the utilization of certain services offered by the provider may be dramatic and unexpected, thus further jeopardizing the provider's ability to contain costs.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. The hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet the hospital's actual costs of care, or if utilization by such enrollees materially exceeds projections, the financial condition of the hospital could erode rapidly and significantly.

Often, HMO contracts are enforceable for a stated term, regardless of hospital losses and may require hospitals to care for enrollees for a certain time period, regardless of whether the HMO is able to pay the hospital. Hospitals also from time to time have disputes with managed care payors concerning payment and contract interpretation issues.

Failure to maintain contracts could have the effect of reducing the market share and net patient services revenues of Aurora. Conversely, participation may result in lower net income if Aurora is unable to adequately contain their costs. Thus, managed care poses a significant business risk that hospitals face.

Recent Legislation. Diverse and complex mechanisms to limit the amount of money paid to health care providers under both the Medicare and Medicaid programs have been enacted, and in particular, have caused severe reductions in reimbursement from the Medicare program. In 2009, the Wisconsin legislature assessed a fee or tax on the gross patient revenues of all Wisconsin hospitals retroactive to July 1, 2008 and imposed a similar tax on the gross patient service revenues of ambulatory surgical centers (the *"Hospital Tax"*). In June 2011, the Governor signed into law the 2011-13 state budget plan, which maintained the Hospital Tax at the same rate provided in the 2009-11 state budget plan for the next two years. The revenues from the Hospital Tax will be used to increase payments made to hospitals for services provided to Medicaid and other medically indigent patients. It is intended that these increased payments to hospitals will also result in increased revenues for the State from the federal government's cost share for Medicaid services. The assessment could have a material adverse effect on the financial condition and results of operations of Aurora if the expense of the assessment imposed on Aurora is significantly greater than the revenues realized by Aurora from increased Medicaid payments. Conversely, if revenues attributable to increased Medicaid payments are greater than the amount of any assessment, then Aurora will realize increased revenues. For the fiscal years ended December 31, 2015 and 2014, Aurora received additional reimbursement resulting from the Hospital Tax. Management of Aurora anticipates that, if the legislation remains in place as currently written, it will result in a net payment to Aurora for the fiscal year ended December 31, 2016.

As noted above, although the Health Care Reform Law expanded Medicaid to all individuals under the age of 65 with incomes less than 138% of the federal poverty level guidelines, Wisconsin has declined to revise its Medicaid programs to cover such individuals.

Regulatory Matters

General. Complex health care laws have been enacted at the federal and state levels to broadly regulate the provision of services to government program beneficiaries and the methods and requirements for submitting claims and receiving reimbursement for such services. A substantial portion of these laws target fraud and abuse and address a broad range of unlawful conduct, including, but not limited to, submitting claims for services that are not in fact provided, submitting false or inaccurate billing information, billing for medically unnecessary services, or billings accompanied by an illegal inducement to utilize or recommend utilization of a service or product. Laws governing fraud and abuse have broad application to hospitals and their financial relationships.

Violation of federal and state fraud and abuse laws may result in a broad range of criminal, civil and administrative sanctions, including the exclusion of a hospital from participation in the Medicare/Medicaid programs, civil monetary penalties, and suspension of Medicare/Medicaid payments, among others. Fraud and abuse cases may be prosecuted by one or more government entities (in many cases as a result of private "whistleblower" actions), and more than one of the available sanctions may be, and often are, imposed for each violation.

Fraud and abuse laws are numerous, highly technical in nature, and frequently changing. Hospitals devote substantial resources to ensure effective compliance with these laws and regulations. Fraud investigations, prosecutions, adjudications, settlements and related publicity resulting from these legal proceedings could have a material adverse effect on the future operations or financial condition of Aurora.

Government Enforcement. To ensure the integrity of the federal health care programs, CMS, HHS, the Office of Inspector General (*"OIG"*) and the DOJ have paid close attention to the business practices and conduct of health care providers. The federal and state governments, including the State of Wisconsin, impose a wide variety of extraordinarily complex and technical requirements intended to prevent over-utilization based on economic inducements, misallocation of expenses, overcharging and other forms of fraud in the Medicare and Medicaid programs, as well as other state and federally funded health care programs. This body of laws and regulations impacts a broad spectrum of hospital commercial activity, including billing, accounting, recordkeeping, medical staff oversight, physician contracting and recruiting, cost allocation, clinical trials, discounts and utilization review, among other activities.

Enforcement actions may pertain to not only deliberate violations but also frequently relate to violations resulting from actions of which management of Aurora is unaware, from mistakes or from circumstances where the individual participants do not know that their conduct is in violation of law. Enforcement actions may extend to conduct that occurred in the past. The government periodically conducts widespread investigations covering categories of services or certain accounting or billing practices.

Violations and alleged violations carry significant sanctions, which may be aggressively pursued by the government. The government may seek a wide array of civil, administrative, criminal and monetary penalties, including withholding essential hospital payments under the Medicare or Medicaid programs, or exclusion from those programs. Negative publicity and large settlements and/or adverse results of litigation could result in payment of substantial fines and prospective restrictions that may have a materially adverse impact on hospital operations, financial condition, results of operations and reputation. Multi-million dollar fines and settlements are common. These risks are generally not covered by insurance. Government enforcement and private whistleblower suits may increase in the hospital and health care sector in the future and may adversely impact hospitals and other health care providers.

Enforcement Activity. Enforcement activity against health care providers has increased, and enforcement authorities may aggressively pursue perceived violations of health care laws. In the current regulatory climate, it is anticipated that many hospitals and physician groups may be subject to an audit, investigation, or other enforcement action regarding the health care fraud laws described below. For example, HHS recently approved federal funding for state Medicaid fraud control units to conduct data-mining activities to detect patterns of abuse. The cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement.

False Claims Laws. There are principally three federal statutes addressing the issue of "false claims." First, the civil FCA imposes civil liability (including substantial monetary penalties and damages) on any person or corporation

that (1) knowingly presents or causes to be presented a false or fraudulent claim for payment to the United States government; (2) knowingly makes, uses or causes to be made or used a false record or statement to obtain payment; or (3) engages in a conspiracy to defraud the federal government by getting a false or fraudulent claim allowed or paid. A showing of specific intent to defraud the federal government is not required to establish the requisite knowledge. "Knowingly" is broadly defined to include not only actual knowledge but also deliberate ignorance or reckless disregard of the facts. This statute authorizes private persons to file *qui tam* actions on behalf of the United States. Because *qui tam* lawsuits are kept under seal while the federal government evaluates whether the United States will join the lawsuit, it is impossible to determine at this time whether any such actions are pending against Aurora and no assurances can be made that such actions will not be filed in the future.

The Fraud and Enforcement and Recovery Act (*"FERA"*), signed into law on May 20, 2009, has expanded potential exposure under the civil FCA for a wide range of business transactions involving federal government funds. Pursuant to FERA amendments, the civil FCA may impose liability for false claims with more remote connections to the federal government. FERA has the effect of expanding liability for the retention of money owed to the government, including overpayments by Medicare. FERA also contains a provision attempting to clarify the obligation regarding overpayments.

The Health Care Reform Law requires a person who receives an overpayment to report and repay the overpayment within 60 days after the overpayment is identified or the date any corresponding cost report is due, whichever is later. The Health Care Reform Law defines overpayments as "any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation is not entitled." Failure to repay any overpayment within the deadline could lead to liability under the FCA.

In addition, the Health Care Reform Law modified the FCA's "public disclosure" bar from one depriving a court of jurisdiction to one requiring dismissal of a barred action or claim. The "public disclosure bar" previously required dismissal of a *qui tam* suit where the allegations were publicly disclosed in a criminal, civil or administrative proceeding; a congressional, administrative or U.S. Government Accountability Office report, hearing, audit or investigation; or news media as a jurisdictional defense to *qui tam* suits. The scope of information that is considered publicly disclosed is now limited to federal information and the news media, not state or local proceedings. These changes broaden the scope of disclosures upon which plaintiffs may rely, likely making it more difficult for defendants to invoke the public disclosure bar defense.

In addition to the civil FCA, the Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to, (1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; (6) using a payment intended for a federal health care program beneficiary for another use; or (7) knowingly making or causing to be made a false statement, omission or misrepresentation of material fact in any application, bid or contract to participate in a federal health care program. The Secretary of HHS, acting through the OIG, also has both mandatory and permissive authority to exclude individuals and entities from participation in federal health care programs pursuant to this statute.

In addition, pursuant to the Health Insurance Portability and Accountability Act (*"HIPAA"*), the commission of either one of the prohibited practices listed below may lead to civil monetary penalties: (1) the practice or pattern of presenting a claim for an item or service on a reimbursement code that the person knows or should know will result in greater payment than appropriate, i.e., upcoding and (2) engaging in a practice of submitting claims for payment for medically unnecessary services. Violation of such prohibited practices could amount to civil monetary penalties of up to $10,000 for each item or service involved.

Finally, it is a criminal federal health care fraud offense to: (1) knowingly and willfully execute or attempt to execute any scheme to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent

pretenses, representations or promises any money or property owned or controlled by any health care benefit program. Penalties for a violation of this federal law include fines and/or imprisonment and a forfeiture of any property derived from proceeds traceable to the offense.

The DRA provides financial incentives to states that pass similar false claims statutes or amend existing false claims statutes that track the FCA more closely with regard to penalties and rewards to *qui tam* relators. It is significant to note that a number of states, including Wisconsin, have passed similar statutes expanding the prohibition against the submission of false claims to nonfederal third-party payors.

The Taxpayer Relief Act increases the recovery period for Medicare overpayments from three years to five years, allowing the government to reach back two additional years to recover Medicare overpayments

At the present time, management of Aurora is not aware of any pending or threatened claims, investigations or enforcement actions regarding the applicable false claims laws which, if determined adversely to Aurora and taking into account current reserves, would have a material adverse effect on the financial condition of Aurora taken as a whole.

The Anti-Kickback Statute. The federal Anti-Kickback Statute makes it a felony to knowingly and willfully offer, pay, solicit or receive remuneration, directly or indirectly, in return for or to induce business that is reimbursable under any federal health care program. The Anti-Kickback Statute applies to many common health care transactions between persons and entities with which a hospital does business including hospital-physician joint ventures, medical director agreements, physician recruitment agreements, physician office leases and other transactions. The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain or pay money for the referral of services or to induce further referrals. Violation of the Anti-Kickback Statute may result in imprisonment for up to five years and/or fines of up to $25,000 for each act. In addition, the OIG has the authority to impose civil assessments and fines and to exclude hospitals engaged in prohibited activities from the Medicare, Medicaid, TRICARE (a health care program providing benefits to dependents of members of the uniformed services), and other federal health care programs for not less than five years. The Health Care Reform Law amended a number of provisions of the Anti-Kickback Statute. One such amendment provides that an Anti-Kickback Statute violation may be established without showing that an individual knew of the statute's proscriptions or acted with specific intent to violate the Anti-Kickback Statute. The new standard could significantly expand criminal and civil fraud exposure for transactions and arrangements where there is no intent to violate the Anti-Kickback Statute. The Health Care Reform Law further amended the Anti-Kickback Statute to explicitly provide that a violation of the statute constitutes a false or fraudulent claim under the FCA.

In addition to certain statutory exceptions to the Anti-Kickback Statute, the OIG has promulgated a number of regulatory "safe harbors" under the Anti-Kickback Statute designed to protect certain payment and business practices. However, these safe harbors are narrow and do not cover a wide range of common economic relationships involving hospitals. The regulations do not purport to comprehensively describe all lawful or unlawful economic arrangements or other relationships between health care providers and referral sources. While the failure to comply with a statutory exception or regulatory safe harbor does not mean that an arrangement is unlawful, such failure may increase the likelihood of a regulatory challenge or the potential for investigation. To date, a limited number of final safe harbors have been established.

Joint Ventures. The OIG has expressed its concern in various advisory bulletins that many types of joint venture arrangements involving hospitals may implicate the Anti-Kickback Statute, since the parties to joint ventures are typically in a position to refer patients of federal health care programs.

In addition, under the federal tax laws governing Section 501(c)(3) organizations, a tax-exempt hospital's participation in a joint venture with for-profit entities must further the hospital's exempt purposes and the joint venture arrangement must permit the hospital to act exclusively in the furtherance of its exempt purposes, with only incidental benefit to any for-profit partners. If the joint venture does not satisfy these criteria, the hospital's tax-exemption may be revoked, the hospital's income from the joint venture may be subject to tax, or the parties may be subject to some other sanction.

Finally, many hospital joint ventures with physicians may also implicate the federal Stark Law.

Any evaluation of compliance with the Anti-Kickback Statute or tax laws governing Section 501(c)(3) organizations depends on the totality of the facts and circumstances, while the Stark Law requires strict compliance with an exception if the prohibition is triggered. Management of Aurora believes that the joint venture arrangements to which Aurora is a party are in material compliance with the Anti-Kickback Statute, OIG pronouncements, the tax laws governing Section 501(c)(3) organizations and the Stark Law, however, there can be no assurance that regulatory authorities will not take a contrary position or that such transactions will not be found to have violated these laws and related regulations. Any determination that Aurora is not in compliance with these laws and related regulations could have a material adverse effect on the future financial condition of Aurora taken as a whole.

Stark Law. Another federal law (commonly known as the "*Stark Law*") prohibits, subject to limited exceptions, a physician who has a financial relationship, or whose immediate family has a financial relationship, with entities (including hospitals) providing "designated health services" from referring Medicare patients to such entities for the furnishing of such designated health services. Such designated health services include inpatient and outpatient hospital services, physical therapy services, occupational therapy services, radiology or other diagnostic services, durable medical equipment, radiation therapy services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, clinical laboratory services and nuclear medicine services and supplies. The Stark Law also prohibits an entity receiving the referral from filing a claim or billing for the services arising out of the prohibited referral unless an exception is met. The prohibition applies regardless of the reasons for the financial relationship and the referral; that is, unlike the federal Anti-Kickback Statute, no finding of intent to violate the Stark Law is required. Sanctions for violation of the Stark Law include denial of payment for the services provided in violation of the prohibition, refunds of amounts collected in violation, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, exclusion from participation in the federal health care programs, and a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law's prohibition. Under an emerging legal theory, knowing violations of the Stark Law may also serve as the basis for liability under the FCA. The types of financial arrangements between a physician and an entity that trigger the self-referral prohibitions of the Stark Law are broad, and include direct and indirect ownership and investment interests and compensation arrangements.

The 2009 IPPS Final Rule published on August 18, 2008 further revised the Stark Law regulations, certain provisions of which became effective on October 1, 2008. Although many of the provisions of the Stark Law regulations were revised, the provisions of the IPPS Final Rule that could have a significant impact on Aurora include: (i) the definition of "entity" and the effect on services provided "under arrangements," (ii) the "stand in the shoes" provisions under which certain physicians are treated as "standing in the shoes" of their "physician organizations," (iii) limitations placed on revenue-based or percentage payments for space and equipment, and (iv) limitations on "per click" arrangements. The definition of an "entity" for Stark purposes now includes the person or entity that performs designated health services, as well as the person or entity that bills for designated health services. The change in definition had a delayed effective date of October 1, 2009. This change significantly affects the manner in which an "under arrangements" relationship may be structured and will require many of those relationships to be restructured or terminated. In addition, many revenue-based and percentage payments for space or equipment may no longer comply with space rental, equipment rental, fair market value, or indirect compensation exceptions. Further, many per-unit or per-click compensation methodologies for space and equipment rental charges no longer comply with space rental, equipment rental, fair market value or indirect compensation exceptions. The changes to percentage based and per-click compensation arrangements also had a delayed effective date of October 1, 2009.

CMS has established a voluntary self-referral disclosure protocol under which hospitals and other health care providers or suppliers may report potential Stark Law violations and seek a reduction in potential refund obligations. However, the self-referral disclosure protocol is relatively new and the parameters used by CMS to determine settlement amounts have not been made public. Therefore, it is difficult to determine at this time the likely settlement amount for any given voluntary disclosure.

Sanctions under the federal Stark Law, including exclusion from the Medicare and Medicaid programs, could have a material adverse effect on the financial condition and results of operations of Aurora. Although management

of Aurora believes that Aurora has used its best efforts to comply with the federal Stark Law, as currently interpreted, and is not aware of any pending or threatened claim, investigation or enforcement action regarding the Stark Law that would have a material adverse effect on the financial condition of Aurora, taken as a whole, there can be no assurance that regulatory authorities will not take a contrary position or that Aurora will not be found to have violated the federal Stark Law.

Physician Recruitment and Service Agreements. The IRS, CMS and OIG have issued various pronouncements that could limit physician service, recruiting and retention arrangements. In IRS Revenue Ruling 97-21, the IRS ruled that tax-exempt hospitals that provide recruiting and retention incentives to physicians risk loss of tax-exempt status unless the incentives are reasonably necessary to address a community need and accordingly provide a community benefit; improvement of a charitable hospital's financial condition does not necessarily constitute such a purpose. With respect to physician service contracts, the IRS takes the position that the compensation paid must be consistent with the value of services actually provided by the physician. The OIG also has taken the position that any arrangement between a federal health care program-certified facility and a physician that is intended even in part to encourage the physician to refer patients may violate the federal Anti-Kickback Statute unless a regulatory exception applies. Physician service, recruitment and retention arrangements may also implicate the Stark Law. While the OIG has promulgated a practitioner recruitment safe harbor to the Anti-Kickback Statute, it is limited to recruitment in areas that are health professional shortage areas (*"HPSAs"*). OIG also requires consistency with fair market for certain other exceptions that may apply to service contracts and may allege that any amount paid above fair market value implies intent to induce referrals. The Stark Law exception for practitioner recruitment is not limited to HPSAs, rather it applies to the recruitment of physicians who are relocating their practices to the geographic area served by the hospital, if certain requirements are met. The Stark Law also contains an exception pertaining to retention arrangements that allows hospitals, in limited circumstances, to pay incentives to retain a physician in underserved areas. In addition, the Stark Law includes certain exceptions that may apply to service contracts, many of which also require (among other things) that payments to the physician are consistent with fair market value for services actually performed.

The sanctions which could be imposed by the IRS or the other regulatory authorities or the courts for violations of IRS regulations, the Stark Law and the Anti-Kickback Statute and for false claims under the FCA and other similar federal or state laws include, among other things, the loss of tax-exempt status of one or more Aurora affiliates, repayment of up to three times the amount of claim payments related to services provided or referred by affected physicians, exclusion of one or more Aurora affiliates from federal health care programs, including the Medicare and Medicaid programs and/or additional monetary penalties.

Aurora has implemented corporate compliance procedures to prevent and detect potential violations of the laws related to physician service, recruitment and retention arrangements. As a part of those procedures, Aurora has reviewed various physician arrangements for compliance with such laws.

Liability Under State Fraud and Abuse Laws. Hospital providers in many states, including Wisconsin, also are subject to a variety of state laws related to false claims (similar to the FCA or that are generally applicable false claims laws) and anti-kickback (similar to the federal Anti-Kickback Statute or that are generally applicable anti-kickback or fraud laws). These prohibitions are similar in public policy and scope to the federal laws, and could pose the possibility of material adverse impact for the same reasons as the federal statutes.

Aurora believes that Aurora has used its best efforts to comply with the Anti-Kickback Statute and the Wisconsin fraud and abuse laws and are in material compliance with the Stark Law. However, because of the breadth of those laws, the narrowness of the safe harbor regulations, and because the exceptions to the Stark Law are narrow and highly technical in nature, and are frequently changing, there can be no assurances that, in the future, regulatory authorities will not take a contrary position or that any Member will not be found to have violated the Anti-Kickback Statute, the Wisconsin fraud and abuse law or the Stark Law.

American Recovery and Reinvestment Act of 2009. The American Recovery and Reinvestment Act of 2009 (the *"Recovery Act"*) was signed into law in February, 2009. The Recovery Act includes certain provisions which are intended to provide financial relief to health care providers. The Recovery Act temporarily increased amounts paid by the federal government to the states to fund Medicaid. Title XIII of the Recovery Act, otherwise known as the Health

Information Technology for Economic and Clinical Health Act (the *"HITECH Act"*), provides for an investment of almost $20 billion in public monies for the development of a nationwide health information technology ("*HIT*") infrastructure. The HIT infrastructure is intended to improve health care quality, reduce health care costs and facilitate access to necessary information. Among other things, the HITECH Act provides financial incentives (through the Medicaid and Medicare programs), as well as loans and grants to encourage practitioners and providers to adopt and use qualified electronic health records. Eventually, Medicare payments will be reduced for providers and practitioners who do not use electronic health records.

The HITECH Act also modified the Health Insurance Portability and Accountability Act of 1996 ("*HIPAA*") (as further discussed below) to strengthen the privacy and security protection for individuals' health information. For example, the HITECH Act significantly increased fines and the scope of remedies for violations of HIPAA and breaches of the security of electronic health records. If certain procedures and technologies are not in place, the HITECH Act requires disclosure to affected individuals, news media and HHS in the event security of protected information is breached. Criminal penalties are enforceable against persons who obtain or disclose protected health information without authorization. In addition, a state's Attorney General can bring civil actions against a person on behalf of residents adversely affected by violations of either HIPAA or the HITECH Act. The Attorney General can either seek to enjoin further violations or obtain money damages on behalf of the residents harmed. HHS is now performing periodic audits of health care providers to ensure that required policies under the HITECH Act are in place. Individuals harmed by violations of HIPAA or the HITECH Act will be able to recover a percentage of monetary penalties or a monetary settlement based upon methods to be established by HHS for this private recovery in the next few years. Any violation of the HITECH Act is subject to HIPAA civil and criminal penalties.

The effect of the Recovery Act, including the HITECH Act, on Aurora cannot be determined at this time. In addition, there is no guarantee that the financial incentives for adopting qualified electronic health records systems will be sufficient to offset Aurora's costs for development and implementation of such a system.

Federal Privacy Laws. HIPAA addresses the confidentiality of individuals' health information. HIPAA requires the establishment of distinct privacy and security protections for individually identifiable health information. HHS promulgated privacy regulations under HIPAA (the *"Privacy Regulations*") that protect patient medical records and other personal health information maintained by health care providers, hospitals, health plans, health insurers and health care clearinghouses. Management of Aurora believes that Aurora's operations and information systems are in compliance with the applicable Privacy Regulations, but no assurance can be given that a violation of such regulations will not be found.

Security regulations (the *"Security Regulations"*) have also been promulgated under HIPAA. Additionally, HHS promulgated regulations to standardize the electronic transfer of information pursuant to certain enumerated transactions (the *"Code Set Transactions"*). Management of Aurora believes that Aurora's health care facilities are in substantial compliance with the Security Regulations and the Code Set Transactions, but no assurance can be given that a violation of such regulations will not be found.

Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of HIPAA and related regulations or authorized by the patient. HIPAA's privacy and security provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions. These add costs and create potentially unanticipated sources of legal liability.

Following years of proposed and interim rulemaking, a final rule implementing a number of changes to the HIPAA privacy, security and enforcement regulations, as provided for in the HITECH Act and other authorities, was published on January 25, 2013 (the *"Omnibus Rule"*). For example, violations of HIPAA can result in civil monetary penalties of up to $25,000 per type of violation in each calendar year and criminal penalties of up to $250,000 per violation. Now these penalties can be even higher-the Omnibus Rule incorporates the tiered civil monetary penalty structure promulgated by the HITECH Act, with civil penalties generally ranging from $100 to $50,000 per violation (with caps of $25,000 to $1.5 million for all violations of a single requirement in a calendar year) depending on the severity of the violation and the level of culpability involved.

The HITECH Act also (i) extends the reach of HIPAA beyond "covered entities," such as healthcare providers, plans and clearing-houses, to their business associates, (ii) imposes a breach notification requirement on HIPAA covered entities, (iii) limits certain uses and disclosures of individually identifiable health information, (iv) restricts covered entities' marketing communications and (v) permits imposition of civil monetary penalties for a HIPAA violation even if an entity did not know and would not, by exercising reasonable diligence, have known of a violation. The Omnibus Rule clarified and expanded many of these provisions, including an expanded definition of "business associate" and enforcement authority over business associates, modification to the standard for reporting breaches of protected health information, and new limitations on the sale of health information and the use of health information in marketing. Covered entities and business associates were required to comply with the Omnibus Rule by September 23, 2013.

Review of Outlier Payments. CMS reviews health care providers that are receiving large proportions of their Medicare revenues from outlier payments. Health care providers found to have obtained inappropriately high outlier payments will be subject to further investigation by CMS and potentially the OIG.

Enforcement Affecting Clinical Research. In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also heightened enforcement of laws and regulations governing the conduct of clinical trials at hospitals. HHS elevated and strengthened its Office of Human Research Protections, one of the agencies with responsibilities for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration (*"FDA"*) also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. The FDA's inspection of facilities increased significantly in recent years. These agencies' enforcement powers range from substantial fines and penalties to exclusions of researchers and suspension or termination of entire research programs. Management of Aurora believes that clinical research being conducted by each Aurora System Entity is in substantial compliance with material applicable requirements.

Exclusive or Anti-Competitive Credentialing. Some hospitals have adopted admissions policies for their medical staffs that deny staff appointment or privileges to physicians that compete against the subject hospital ("exclusive" or "economic" "credentialing"). CMS has announced that it will examine whether exclusive credentialing violates provisions of federal law, including the Stark Law. CMS action could lead to regulations prohibiting or restricting exclusive credentialing. Any final rule or regulation of CMS on exclusive credentialing could adversely affect Aurora's policies.

Emergency Medical Treatment and Active Labor Act. The federal Emergency Medical Treatment and Active Labor Act (*"EMTALA"*) imposes certain requirements on hospitals and facilities with emergency departments. Generally, EMTALA requires that hospitals and other facilities with emergency department facilities provide "appropriate medical screening" to patients who come to the emergency department to determine if an emergency medical condition exists. The hospital must stabilize the patient within the capabilities of the hospital, and the patient cannot be transferred unless stabilization has occurred or unless such transfer is done pursuant to EMTALA requirements.

Failure to comply with EMTALA may result in a hospital's exclusion from the Medicare and/or Medicaid programs, as well as civil monetary penalties. As such, failure of Aurora to meet its responsibilities under EMTALA could adversely affect Aurora's financial condition.

Management of Aurora believes that its policies and procedures are in material compliance with the applicable provisions of EMTALA, but no assurance can be given that a violation of EMTALA will not be found. Any sanctions imposed as a result of an EMTALA violation could have a material adverse effect on the future operations or financial condition of Aurora taken as a whole.

ICD-10 Coding. All healthcare providers covered by HIPPA, including Aurora hospitals, are required to transition by October 1, 2015 to the ICD-10 code set used to report medical diagnoses and inpatient procedures. ICD-10 significantly expands the number of and detail in the codes used to bill providers for inpatient services. Aurora completed the process of transitioning all of its hospitals to the ICD-10 code set, which involved a significant amount of capital investment in technology and coding of Aurora's information systems, as well as significant costs for training of staff

involved with coding and billing. If there is difficulty in transitioning our coding and billing processes to this significantly more detailed code set, we could experience a material adverse effect on our operations and our consolidated results of operations.

Licensing, Surveys, Investigations and Audits. Health facilities are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and the Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses could reduce hospital utilization or revenues or hinder a hospital's ability to operate all or a portion of its facilities, and, consequently, could adversely affect Aurora's financial condition. No assurance can be given as to the effect on future operations of existing laws, regulations and standards for certification or accreditation or of any future changes in such laws, regulations and standards.

Environmental Laws and Regulations. Aurora is subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. These include, but are not limited to: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital; and requirements for training employees in the proper handling and management of hazardous materials and wastes.

Aurora may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with compliance with such environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance. There is no assurance that Aurora will not encounter such problems in the future, and such problems may result in material adverse consequences to the operations or financial condition of Aurora.

At the present time, management of Aurora is not aware of any pending or threatened claim, investigation or enforcement action regarding such environmental issues which, if determined adversely to any Aurora System Entity, would have a material adverse effect on its financial condition of Aurora taken as a whole.

Business Relationships and Other Business Matters

Accountable Care Organizations. Many hospitals and health systems are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician and hospital services, to patients, health care insurers and managed care providers. The Health Care Reform Law encourages the development of health care delivery models that are designed to enhance quality and reduce cost and that will effectively require greater integration between and collaboration among hospitals and physicians by allowing accountable care organizations ("ACOs") that meet quality thresholds to share in the savings achieved for the Medicare Program. The Health Care Reform Law requires the Secretary of HHS to implement a shared savings program ("MSSP") that will allow providers, such as hospitals and physicians, to organize as ACOs, and to implement a voluntary demonstration project to develop ACOs for pediatric patients under the Medicaid program.

To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. In November 2011, CMS published the final rules regarding ACOs. Although the regulation provides for waivers for certain federal laws, there may be regulatory risks for hospitals, in addition to the financial and operational risks. The applicable regulating bodies have published guidance for ACOs

to follow in order to comply with the law, but the published guidance is complex. On March 31, 2011, the Federal Trade Commission ("FTC") and the DOJ issued a joint proposed statement of antitrust enforcement policy as applied to ACOs; CMS and the OIG issued a joint notice on waivers of the Anti-kickback Statute, Stark law and the Civil Monetary Penalty laws; and the IRS issued a notice on the impact on tax-exempt organizations participating in ACOs. Numerous organizations have formed ACOs and been selected by CMS to participate in the MSSP. In December 2014, CMS proposed an additional rule to make certain changes to the regulations governing the MSSP, including allowing current ACOs to take on more performance-based risk. Private insurers have been seeking to establish similar incentives for providers, while requiring less infrastructural and organizational change.

The impact this guidance will have upon the health care marketplace is unknown and cannot be predicted. The potential impacts of these initiatives and the regulation of ACOs are unknown but introduce greater risk to health care finance and operations. Aurora has and will continue to monitor related programs and opportunities that may arise in connection with various ACO models.

Integrated Physician Groups. As an integrated health care delivery system, Aurora employs large numbers of physicians and has relationships with certain other physician groups.

Many hospitals and health systems are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician and hospital services, to patients, health care insurers and managed care providers. These integration strategies may take many forms, including management service organizations (*"MSOs"*) that provide physicians or physician groups with a combination of financial and managed care contracting services, office and equipment, office personnel and management information systems. Integration objectives may also be achieved via physician-hospital organizations or primary health organizations, organizations which are typically jointly owned or controlled by a hospital and physician group for the purpose of managed care contracting, implementation and monitoring. Other integration structures include hospital-based clinics or medical practice foundations, which may purchase and operate physician practices as well as provide all administrative services to physicians. Additionally, some hospitals and health systems are pursuing accountable care arrangements, which include varying degrees of clinical and financial integration with physician groups and other health care providers to improve efficiencies and quality outcomes for population-management in a risk-sharing model. Many of these integration strategies are capital intensive and may create certain business and legal liabilities for the related hospital or health system.

Often the start-up capitalization for such structures, as well as operational deficits, are funded by the sponsoring hospital or health system. Depending on the size and organizational characteristics of a particular strategy, these capital requirements may be substantial. In some cases, the sponsoring hospital or health system may be asked to provide a financial guarantee for the debt of a related entity which is carrying out an integrated delivery strategy. In certain of these structures, the sponsoring hospital or health system may have an ongoing financial commitment to support operating deficits, which may be substantial on an annual or aggregate basis. In addition, participating physicians may seek their independence for a variety of reasons, thus putting the hospital or health system's investment at risk and potentially reducing its managed care leverage and/or overall utilization.

These types of alliances are generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care to increase physician availability to the community and/or to enhance the managed care capability of the affiliated hospitals and physicians. However, these goals may not be achieved, and an unsuccessful alliance may be costly and counterproductive to all of the above-stated goals.

All such integrated delivery strategies carry with them the potential for legal or regulatory risks in varying degrees. Such strategies may call into question compliance with the Medicare fraud and abuse laws, relevant antitrust laws and federal or state tax exemption. Such risks will turn on the facts specific to the implementation, operation or future modification of any integrated delivery system. In addition, depending on the type of structure, a wide range of governmental billing and other issues may arise, including questions of the authorization of the entity to bill for or on behalf of the physicians involved. Other related legal and regulatory risks may arise, including employment, pension and benefits and corporate practice of medicine, particularly in the current atmosphere of frequent and often unpredictable changes in federal and state legal requirements regarding health care and medical practice. The ability

of hospitals or health systems to conduct integrated physician operations may also be altered or eliminated in the future by legal or regulatory interpretation or changes or by health care fraud enforcement.

Hospital Pricing. Inflation in hospital costs may evoke action by legislatures, payors or consumers. It is possible that legislative action at the state or national level may be taken with regard to the pricing of health care services.

Physician Medical Staff. The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges or who have such membership or privileges curtailed or revoked often file legal actions against hospitals and medical staffs. Such actions may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. Furthermore, from time to time, actions or decisions of hospital management may cause unrest among certain physician groups or members of the medical staff, which could result in legal or other actions, such as resignation from the medical staff. In addition, failure of the hospital governing body to adequately oversee the conduct of its medical staff may result in hospital liability to third parties.

Physician Supply. Sufficient community-based physician supply is important to hospitals and health systems. The shortage of physicians could become a significant issue for health providers to face in the coming years. Any physician shortage will be compounded by the expansion of coverage to the uninsured under the Health Care Reform Law. In addition, CMS annually reviews overall physician reimbursement formulas. Changes to physician compensation formulas could lead to physicians locating their practices in communities with lower Medicare and Medicaid populations. Aurora may be required to invest additional resources for recruiting and retaining physicians, or may be required to increase the percentage of employed physicians in order to continue serving the growing population base and maintain market share.

Physician Contracting. Aurora may contract with physician organizations (such as independent physician associations, physician-hospital organizations and accountable care organizations) to arrange for the provision of physician and ancillary services. Because physician organizations are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with physician organizations.

The success of Aurora is partially dependent upon their ability to attract physicians to join the physician organizations at facilities operated by Aurora affiliates and to participate in their networks, and upon the ability of the physicians, including the employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that Aurora will be able to attract and retain the requisite number of physicians, or that physicians will deliver high quality health care services. Without contracting with a sufficient number and type of providers, Aurora could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until its physician organizations provide adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of Aurora.

Competition among Health Care Providers. Increased competition from a wide variety of sources, including specialty hospitals, other hospitals and health care systems, inpatient and outpatient health care facilities, long-term care and skilled nursing services facilities, clinics, physicians and others, may adversely affect the utilization and/or revenues of hospitals. Existing and potential competitors may not be subject to various restrictions applicable to hospitals, and competition, in the future, may arise from new sources not currently anticipated or prevalent.

Specialty hospitals that attract away an important segment of an existing hospital's admitting specialists may be particularly damaging. For example, some large hospitals may have significant dependence on heart surgery programs, as revenue streams from those programs may cover significant fixed overhead costs. The expiration of the Stark Law moratorium on physician investment in specialty hospitals in 2005 led to an increase in physician-owned hospitals. Effective December 31, 2010, the Health Care Reform Law banned new physician-owned hospitals and prohibited existing physician-owned hospitals from expanding the number of operating rooms, procedure rooms, or

beds for which a hospital was licensed as of March 23, 2010 unless an exception is requested and granted by the U.S. Department of Health and Human Services ("*HHS*"). Nonetheless, specialty hospitals formed by December 31, 2010 continue to represent a significant competitive challenge for full-service hospitals.

Additionally, scientific and technological advances, new procedures, drugs and appliances, preventive medicine and outpatient health care delivery may reduce utilization and revenues of the hospitals in the future or otherwise lead the way to new avenues of competition. In some cases, hospital investment in facilities and equipment for capital-intensive services may be lost as a result of rapid changes in diagnosis, treatment or clinical practice brought about by new technology or new pharmacology.

Cyber Security. We rely extensively on our computer systems to manage clinical and financial data, communicate with our patients, payors, vendors and other third parties and summarize and analyze operating results. In addition, we have made significant investments in technology to adopt and utilize electronic health records and to become meaningful users of health information technology pursuant to the American Recovery and Reinvestment Act of 2009. There can be no assurance that we will not be subject to cybersecurity attacks in the future that bypass Aurora's security measures, result in loss of protected health information or other data subject to privacy laws or disrupt Aurora's IT systems or business. As a result, cybersecurity and the continued development and enhancement of Aurora's controls, processes and practices designed to protect Aurora's systems, computers, software, data and networks from attack, damage or unauthorized access are a priority for us. As cyber threats continue to evolve, we may be required to expend significant resources to continue to modify or enhance Aurora's protective measures or to investigate and remediate any information security vulnerabilities. If we are subject to cyber-attacks or security breaches in the future, this could have an adverse impact on Aurora's business, financial condition or results of operations.

Antitrust

Enforcement of the antitrust laws against health care providers is becoming more common and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third-party contracting, physician relations and joint venture, merger, affiliation and acquisition activities. Enforcement activity by federal and state agencies in the health care sector continues to be very active. In particular, the Federal Trade Commission (the *"FTC"*) has publicly acknowledged increasing enforcement action in the areas of hospital and physician combinations. Violation of the antitrust laws could subject a hospital to criminal and civil enforcement by federal and state agencies, as well as treble damage liability by private litigants. At various times, Aurora may be subject to an investigation by a governmental agency charged with the enforcement of the antitrust laws or may be subject to administrative or judicial action by a federal or state agency or a private party.

The most common areas of potential liability are joint activities among providers with respect to payor contracting, medical staff credentialing, hospital and physician mergers and acquisitions and allegations of exclusion of competitors from market opportunities. From time to time, Aurora may be involved in joint contracting activity or affiliation discussions with other hospitals or providers. The precise degree to which this or similar joint activities may expose Aurora to antitrust risk from governmental or private sources is dependent on specific facts which may change from time to time. Physicians who are subject to adverse peer review proceedings may file federal antitrust actions against hospitals, although the Health Care Quality and Improvement Act may provide immunity from such claims if certain requirements are met. Hospitals regularly have disputes regarding credentialing and peer review and therefore may be subject to liability in this area.

In addition, hospitals occasionally indemnify medical staff members who are involved in such credentialing or peer review activities and may also be liable with respect to such indemnity. Recent court cases have challenged alleged agreements to exclude competitors from managed care networks. Such activities may result in monetary liability for the participating hospitals under certain circumstances where a competitor suffers business damage. Government or private parties are entitled to challenge mergers, acquisitions, joint ventures, or other affiliations that may injure competition. Liability in any of these or other antitrust areas of liability may be substantial, depending on the facts and circumstances of each case and may have a material adverse impact on Aurora.

Negative Rankings Based on Clinic Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures

Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "P4P" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers such as Aurora. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction, and investment in health information technology. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition.

Other Health Care Professionals and Employees

Labor Relations and Collective Bargaining. Hospitals are large employers with a wide diversity of employees. Increasingly, employees of hospitals are becoming unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. The Employee Free Choice Act was introduced in Congress on March 10, 2009 with the stated purpose of amending the National Labor Relations Act to establish an easier system to enable employees to form, join, or assist labor organizations and to provide for mandatory injunctions for unfair labor practices during organizing efforts. It is uncertain at this time whether this proposed legislation will become law, or if it does, what its final provisions will be. To date, it has not become law. In its present form, it would make it easier for employees to join collective bargaining units at Aurora's facilities. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to hospitals. Employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and hospital reputation.

Wage and Hour Class Actions and Litigation. Federal law and many states impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards. In recent years there has been a proliferation of lawsuits over these "wage and hour" issues, often in the form of large, sometimes multi-state, class actions. For large employers such as hospitals and health systems, such class actions can involve multi-million dollar claims, judgments and/or settlements. A major class action decided or settled adversely to Aurora could have a material adverse impact on its financial condition and result of operations.

Health Care Worker Classification. Health care providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. If the IRS were to reclassify a significant number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

Staffing. The health care industry has historically suffered from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained health care technicians. In recent years, these shortages have lessened. However, it is possible such shortages will reappear if the national economic conditions improve and demand for professional and technical staff increases. Competition for employees, coupled with increased recruiting and retention costs, will increase hospital operating costs, possibly significantly, and growth may be constrained. This trend could have a material adverse impact on the financial conditions and results of operations of hospitals.

Pension and Benefit Funds. As large employers, hospitals may incur significant expenses to fund pension and benefit plans for employees and former employees and to fund required workers' compensation benefits. Funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed for other purposes. In addition, to the extent investment returns are lower than anticipated or losses on investments occur, Aurora may also be required to make additional deposits in connection with pension fund liabilities.

Professional Liability Claims and General Liability Insurance

In recent years, the number of professional and general liability suits and the dollar amounts of damage recoveries have increased in health care nationwide, resulting in substantial increases in malpractice insurance premiums, higher deductibles and generally less coverage. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against health care providers. Insurance does not provide coverage for judgments for punitive damages.

Litigation also arises from the corporate and business activities of hospitals, from a hospital's status as an employer or as a result of medical staff or provider network peer review or the denial of medical staff or provider network privileges. As with professional liability, certain of these risks may not be covered by insurance. For example, some antitrust claims or business disputes are not covered by insurance and may, in whole or in part, become a direct liability of Aurora if determined or settled adversely.

There is no assurance that hospitals will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover malpractice judgments rendered against a hospital or that such coverage will be available at a reasonable cost in the future.

Future Legislation

Legislation is periodically introduced in the U.S. Congress and in the legislature of the State of Wisconsin that could result in limitations on hospital revenues, reimbursement, costs or charges or that could require an increase in the quantity of indigent care required to maintain charitable status. The effect on Aurora of any such proposals, if enacted, cannot be determined at this time.

In addition to legislative proposals previously discussed herein, other legislative proposals that could have an adverse effect on Aurora include: (a) any changes in the taxation of not for profit corporations or in the scope of their exemption from income or property taxes; (b) limitations on the amount or availability of tax exempt financing for corporations described in Section 501(c)(3) of the Code; and (c) regulatory limitations affecting the ability of Aurora to undertake capital projects or develop new services.

Legislative bodies, including Congress as described above, have considered legislation concerning the charity care standards that nonprofit, charitable hospitals must meet to maintain their federal income tax-exempt status under the Code and legislation mandating that nonprofit, charitable hospitals have an open-door policy toward Medicare and Medicaid patients as well as offer, in a non-discriminatory manner, qualified charity care and community benefits. Excise tax penalties on nonprofit, charitable hospitals that violate these charity care and community benefit requirements could be imposed or their tax-exempt status under the Code could be revoked. The scope and effect of legislation, if any, that may be enacted at the federal or state levels with respect to charity care of nonprofit hospitals cannot be predicted. Any such legislation or similar legislation, if enacted, could have the effect of subjecting a portion of the income of Aurora to federal or state income taxes or to other tax penalties and adversely affect the ability of Aurora to generate net revenues sufficient to meet their obligations and to pay the debt service on its Indebtedness.

Maintenance of the Tax-Exempt Status of Aurora

The tax exempt status of interest on bonds issued for the benefit of Aurora depends, among other things, upon maintenance by Aurora affiliates that operate facilities financed or refinanced with the proceeds of the related bonds and maintenance of their status as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the *"Code"*). The maintenance of such status is contingent on compliance with general rules based on the Code, Treasury regulations and judicial decisions regarding the organization and operation of tax-exempt hospitals and health systems. The IRS' interpretation of and position on these rules as they affect the organization and operation of health care organizations (for example, with respect to providing charity care, joint ventures, physician and executive compensation, physician recruitment and retention, etc.) are constantly evolving. The IRS can and in fact occasionally does alter or reverse its positions concerning tax-exemption issues, even concerning long-held positions upon which tax-exempt health care organizations have relied.

In addition to violations of the Code and Treasury regulations, the IRS has asserted that tax-exempt hospitals that are in violation of Medicare and Medicaid regulations regarding inducement for referrals may also be subject to

revocation of their tax-exempt status. Because a wide variety of hospital-physician transactions potentially violate these broadly stated prohibitions on inducement for referrals, the IRS has broadened the range of activities that may directly affect tax exemption, without defining specifically how those rules will be applied. As a result, tax-exempt hospitals, particularly those that have extensive transactions with physicians, are currently subject to an increased degree of scrutiny and perhaps enforcement by the IRS. The IRS's policy position is not necessarily indicative of a judicial determination of the applicable issues.

Section 4958 of the Code imposes excise taxes on "excess benefit transactions" between "disqualified persons" and tax-exempt organizations such as Aurora tax-exempt affiliates. According to the legislative history and regulations associated with Section 4958, these excise taxes may be imposed by the IRS either in lieu of or in addition to revocation of exemption. These intermediate sanctions may be imposed in situations in which a "disqualified person" (such as a voting member of the board, certain officers and others in a position to exercise substantial influence over the affairs of the exempt organization) engages in "excess benefit transactions" such as (i) a transaction with a tax-exempt organization on other than a fair market value basis, (ii) receipt of unreasonable compensation from a tax-exempt organization or (iii) receipt of payment in an arrangement that otherwise violates the prohibition against private inurement. A disqualified person who benefits from an excess benefit transaction will be subject to an excise tax equal to 25% of the amount of the excess benefit. Organization managers who participate in the excess benefit transaction knowing it to be improper are subject to an excise tax equal to 10% of the amount of the excess benefit, subject to a maximum penalty of $20,000 per transaction. A second penalty, in the amount of 200% of the excess benefit, may be imposed on the disqualified person (but not upon the organization manager) if the excess benefit is not corrected within a specified period of time. Fair market value and reasonable compensation for tax purposes typically reflect a range rather than a specific dollar amount, and the IRS does not rule in advance on whether a transaction results in more than fair market value payment or more than reasonable compensation to a disqualified person. Although it is not possible to predict what enforcement action, if any, the IRS might take related to potential excess benefit transactions, the regulations indicate that not all excess benefit transactions jeopardize exempt status. Rather, the IRS will consider all relevant facts and circumstances including: the size and scope of the organization's activities that further exempt purposes before and after the excess benefit transaction or transactions occurred; the size and scope, and frequency, of any excess benefit transactions; whether the organization has implemented appropriate safeguards reasonably calculated to prevent excess benefit transactions; and whether the organization has corrected, or made good faith efforts to correct, any excess benefit such as by obtaining repayment of the amount of any excess benefit.

Moreover, the legislation is potentially favorable to taxpayers because it provides the IRS with a punitive option short of revocation of exempt status to deal with incidents of private inurement. However, the standards for tax exemption have not been changed, including the requirement that no part of the net earnings of an exempt entity inure to the benefit of any private individual. Consequently, although the IRS has only infrequently revoked the tax exemption of nonprofit health care corporations in the past, the risk of revocation remains and there can be no assurance that the IRS will not direct enforcement activities against any of Aurora affiliates.

In certain cases, the IRS has imposed substantial monetary penalties and future charity care or public benefit obligations on tax-exempt hospitals in lieu of revoking their tax-exempt status, as well as requiring that certain transactions be altered, terminated or avoided in the future and/or requiring governance or management changes. These penalties and obligations are typically imposed on the tax-exempt hospital pursuant to a "closing agreement" with respect to the hospital's alleged violation of Section 501(c)(3) exemption requirements. Given the uncertainty regarding how tax-exemption requirements may be applied by the IRS, Aurora non-profit affiliates are, and will be, at risk for incurring monetary and other liabilities imposed by the IRS through this "closing agreement" or similar process. Like certain of the other business and legal risks described herein which apply to large multi-hospital systems, these liabilities are probable from time to time for some systems in the nonprofit health care industry and could be substantial, in some cases involving millions of dollars, and in extreme cases could be materially adverse.

The Health Care Reform Law places additional requirements on tax-exempt hospitals for them to receive and maintain their Section 501(c)(3) federal tax exempt status. One significant new requirement is that tax-exempt hospitals must perform a community health needs assessment every three years and develop an implementation strategy to meet the identified needs. Requirements relating to community health needs assessments are effective for taxable years beginning after March 23, 2012, while other requirements are effective for taxable years beginning after March 23,

2010. Any tax-exempt hospital that fails to satisfy the community health needs assessment requirement for any taxable year will be subject to an excise tax penalty of $50,000. Furthermore, the United States Secretary of the Treasury or that individual's delegate is to review the community benefit activities of each tax-exempt hospital at least every three years. Another major element of the Health Care Reform Law relating to tax-exempt status of hospitals involves charges. A hospital must limit the amounts charged for emergency room or other medically necessary care provided to patients eligible for assistance under the hospital's financial assistance policy to no more than the amounts generally billed to patients who have insurance covering such care. In other words, hospitals cannot charge persons eligible for financial assistance higher rates than the amounts generally billed to patients who have insurance covering such care. The Health Care Reform Law also requires that tax-exempt hospitals have a written financial assistance policy in place. Finally, the Health Care Reform Law prohibits a hospital from engaging in extraordinary collection actions (which may include, among other things, a restriction on filing suit) before it has made reasonable efforts to determine whether the subject individual is eligible for financial assistance. On September 24, 2012, the IRS issued proposed regulations interpreting various portions of these new requirements, on which taxpayers may rely until final or temporary regulations are issued. The IRS has not yet issued proposed regulations regarding the community health needs assessment, but has issued interim guidance. As such, the interpretation of these new requirements is subject to change as the IRS releases further guidance and eventually final regulations.

The Tax Exempt and Governmental Entities Division of the IRS is responsible for the Team Examination Program (referred to as *"TEP"*) of the IRS, which conducts audits of exempt organizations using teams of revenue agents. The TEP audit teams consider a wide range of possible issues, including the community benefit standard, private inurement and private benefit, partnerships and joint ventures, retirement plans and employee benefits, employment taxes, tax-exempt bond financing, political contributions and unrelated business income. In addition, the IRS conducts compliance checks and correspondence audits that focus initially on limited issues, such as executive compensation, unrelated business income or community benefit. Such limited scope reviews can be expanded in certain circumstances to include a variety of other issues as in a TEP audit.

One or more of Aurora non-profit affiliates could be audited by the IRS. Management of Aurora believes that Aurora is in material compliance with the tax laws. Nevertheless, because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, a TEP or other audit could result in additional taxes, interest and penalties. A TEP or other audit also could potentially affect the tax-exempt status of any of Aurora affiliates.

Loss of tax-exempt status by certain Aurora affiliates could result in loss of the exclusion from gross income of the interest on bonds issued for the benefit of Aurora. Such loss could result in a default under the related documents and agreements, potentially triggering an acceleration of the related bonds. Any such event would have material adverse consequences on the future financial condition and results of operations of Aurora, including adversely affecting its access to future tax-exempt financing.

Charity Care, Underinsured and Uninsured Patients

Recently, focus has increased on the provision of charity care by not for profit health care institutions and their pricing policies and billing and collection practices involving the underinsured and uninsured. This increased focus has resulted in congressional hearings, governmental inquiries and private, purported class action litigation against a number of not for profit health care institutions generally alleging the overcharging of underinsured and uninsured patients. In addition, lawsuits have been filed in both federal and state courts alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. Aurora has not been served with a complaint relating to any such litigation. Management of Aurora cannot predict the impact that these or related developments may have on Aurora or the health care industry as a whole.

Other Risk Factors

In the future, the following factors, among others, may adversely affect the operations of health care providers, including Aurora, to an extent that cannot be determined at this time:

1. Costs and availability of any insurance, such as professional liability, fire, automobile and general comprehensive liability coverages, which health care facilities of a similar type generally carry.

2. Efforts by insurers and governmental agencies to limit the cost of hospital services provided by Aurora, to reduce the number of beds and to reduce the utilization of facilities of Aurora by such means as preventive medicine, improved occupational health and safety and outpatient care, or comparable regulations or attempts by third-party payors to control or restrict the operations of health care facilities.

3. Reduced demand for services of Aurora that might result from decreases in the population of their service areas.

4. Reduced utilization of hospital facilities as a result of other factors, including trends in physician practices toward fewer inpatient admissions, changes in services offered by hospitals, shorter lengths of stay for admitted patients and increased outpatient surgery at ambulatory care facilities.

5. Imposition of wage and price controls for the health care industry.

6. Increased unemployment or other adverse economic conditions in the service areas of Aurora which would increase the proportion of patients who are unable to pay fully for the cost of their care.

7. Increases in the quantity of uncompensated care provided by Aurora, including care for indigent persons.

8. The ability of Aurora to attract a sufficient number of qualified physicians, nurses and other health care professionals.

9. The occurrence of natural disasters, including floods and tornadoes, which may Aurora's facilities, interrupt utility services to such facilities or otherwise impair the operation of Aurora and the generation of revenues from the facilities.

10. Employee strikes and other adverse labor action by employees including the cost and effect of any future unionization of employees.

11. Potential depletion of the Medicare Trust Fund.

12. The possible inability to obtain future governmental approvals to undertake projects necessary to remain competitive both as to rates and charges as well as quality and scope of care could adversely affect the operations of Aurora.

13. Potential insolvency of the Common Ground Healthcare Cooperative.

14. Site of service designation changes resulting in denials of certain procedures at certain Aurora Sites.