S&P Global
Ratings

RatingsDirect®

Advocate Health Care Network, Illinois; System

Primary Credit Analyst:
Suzie R Desai, Chicago (1) 312-233-7046; suzie.desai@spglobal.com

Secondary Contact:
Allison Bretz, Chicago (1) 303-721-4119; allison.bretz@spglobal.com

Table Of Contents

Advocate Health Care Network, Illinois; System

Credit Profile		
US$730.0 mil rev bnds (Advocate Hlth Care) ser 2018 dtd 08/08/2018 due 05/01/2048		
Long Term Rating	AA/Stable	New
US$200.0 mil rev bnds (Advocate Hlth Care) ser 2018C due 05/01/2037		
Long Term Rating	AA/Stable	New
US$200.0 mil rev bnds (Advocate Hlth Care) ser 2018B due 05/01/2037		
Long Term Rating	AA/Stable	New
US$100.0 mil rev bnds (Advocate Hlth Care) ser 2018A due 05/01/2037		
Long Term Rating	AA/Stable	New
Illinois Finance Authority, Illinois		
Advocate Hlth Care, Illinois		
series 2008A-1/A-2/A-3		
Long Term Rating	AA/Stable	Downgraded
series 2011B windows		
Long Term Rating	AA/A-1+/Stable	Downgraded
ser 2008C-2A		
Long Term Rating	AA/A-1/Stable	Downgraded
Series 2008D, 2010A-D, 2011A, 2012, and 2013A		
Long Term Rating	AA/Stable	Downgraded
Series 2008C-1, 2008C-2B		
Long Term Rating	AA/A-1/Stable	Downgraded
Series 2008C-3A		
Long Term Rating	AA/A-1+/Stable	Downgraded
Illinois Hlth Fac Auth, Illinois		
Advocate Hlth Care, Illinois		
Illinois Hlth Fac Auth (Advocate Hlth Care Network) sys		
Long Term Rating	AA/Stable	Downgraded
Illinois Hlth Fac Auth (Advocate Hlth Care Network) sys		
Long Term Rating	AA/Stable	Downgraded

Rationale

S&P Global Ratings lowered its long-term rating to 'AA' from 'AA+' on the Illinois Finance Authority's various series of fixed-rate tax-exempt bonds. At the same time, S&P Global Ratings lowered the long-term component of its dual ratings to 'AA' ('AA/A-1+' and 'AA/A-1') from 'AA+', where applicable, on the authority's various series of variable-rate demand bonds (VRDBs). Finally, S&P Global Ratings assigned its 'AA' long-term rating to the Wisconsin

Health and Educational Facilities Authority's $730.0 million series 2018 taxable revenue bonds, $100.0 million series 2018A fixed rate tax-exempt revenue bonds, $200 million series 2018B variable rate tax-exempt revenue bonds (issued as mandatory tender bonds), and $200 million series 2018C variable rate tax-exempt revenue bonds (issued as floating rate notes). All bonds were issued for Advocate Health Care Network (AHCN). The outlook, where applicable, is stable.

Effective April 1, 2018, AHCN merged with Aurora Health Care (AHC) to form Advocate Aurora Health Inc. (AAH). Concurrent with the issuance of the series 2018 bonds, AHCN will issue a supplemental master trust indenture to incorporate the majority of AHC's facilities into the existing AHCN obligated group, along with the parent corporation, AAH. As the new obligated group accounts for the majority of the assets and revenue of AAH, our rating is based on AAH as a whole. Management has provided combined pro forma financial results for fiscal years 2016 and 2017 as well as interim 2018 (through March 31). These results are based on legacy system audited financial results that we have also reviewed, and we view the pro forma results as consistent with those audits. S&P Global Ratings has not historically carried a long-term rating on legacy AHC debt.

The series 2018 proceeds will go toward refinancing all of AHC's long-term debt outstanding (as well as a small amount outstanding on a line of credit), and the previous legacy AHC's obligated group and security will be terminated after legacy AHC bondholders have been paid in full. The 2018B and 2018C bonds will likely be remarketed in tranches on six-month cycles beginning in 2021, but final details will be available as those bonds are marketed.

The rating action reflects our view of the combined AAH's generally weaker pro forma financial profile, particularly on the balance sheet, where cash on hand and unrestricted reserves to debt are robust but more commensurate with the 'AA' rating. However, we believe the combined AAH has ample flexibility at the current rating given a stronger and more diversified enterprise profile and a similar operating profile when compared with AHCN's prior metrics.

Specifically, the 'AA' rating reflects our expectation that AAH will continue to build on its already excellent enterprise profile and leading market position in the broad Chicagoland and eastern Wisconsin markets. AAH now has considerable size and scale with more than $11 billion in revenue and more than $16 billion in assets, servicing a very large population base. In addition, we believe AAH can further benefit from both systems' legacy strengths, including AHCN's national reputation for developing a strong clinically integrated physician network model that has allowed it to manage increasing value-based reimbursement as well as legacy AHC's large employed physician model. We expect AAH's financial operating profile and maximum annual debt service (MADS) coverage to remain healthy as a result of growth initiatives, significant cost restructuring and expense management, and broader synergies from the combined entity. In addition, we expect that AAH will manage its capital spending and maintain AAH's overall balance sheet profile. We believe that AAH is on track with its integration plans and expect more details regarding AAH's future growth and focus as management completes its strategic plan over the next several months.

The 'AA' long-term rating reflects our view of AAH's:

- Broad and diverse position across two states, including the broad Chicago metro, Southern Illinois, and Eastern Wisconsin markets, coupled with individual legacy enterprise strengths around clinical integration, employed physician models, and sound accountable care organization (ACO) and risk-based payer strategies;
- Healthy pro forma balance-sheet measures with light leverage of 22%, solid unrestricted reserves of 252 days' cash

on hand, and unrestricted reserves to long-term debt of over 250% (and with slightly healthier unrestricted-reserve-related metrics when including self-insurance reserves from legacy AHCN) as of March 31, 2018;

- Leading and incrementally increasing market share for the system as a whole although AAH operates in very competitive markets; and
- Consistently sound pro forma MADS coverage (smoothed) of more than 6x for the past few years.

Partly offsetting the above strengths, in our view, are AAH's:

- Strong competition in almost all of the markets that AAH operates in--from other systems and large academic medical centers--coupled with broader volume pressures related to both the health care industry and the economy; and
- Lighter operating margin trend over the past few years, though generally consistent with industry trends (fiscal 2017 incorporated significant one-time expenses); and
- Continued exposure to Illinois Medicaid (through legacy AHCN), although AAH's diversification and improved timeliness of Medicaid payments (with an updated provider tax also recently passed) somewhat mitigates this.

The 'A-1+' short-term component of the rating on the series 2008C-3B mandatory tender bonds and 2011B windows bonds reflects our view of the credit strength inherent in the 'AA+' long-term rating on legacy AHCN's debt and the sufficiency of AHCN's unrestricted reserves to provide liquidity support for the bonds. We note that management expects to fully redeem the series 2008C-3B bonds on the mandatory tender date (July 30, 2018). Our Fund Ratings and Evaluations Group assesses the liquidity of AHCN's unrestricted investment portfolio to determine the adequacy and availability of these funds to guarantee the timely purchase of the bonds tendered in the event of a failed remarketing. We monitor the liquidity and sufficiency of AHCN's investment portfolio monthly.

The 'A-1+' short-term component of the rating on the issuer's series 2008C-2A and 2008C-3A bonds, and the 'A-1' short-term component of the rating on the series 2008C-1 and 2008C-2B bonds reflect our view of the standby bond purchase agreements (SBPAs) in effect from various financial institutions. They further reflect our view of the likelihood of payment of tenders, and our view of liquidity facilities that cover all of the bond series. (For more information, see the Financial Profile section.)

Outlook

The stable outlook reflects our view of AAH's sound and improving business position in its various core markets coupled with a very sound financial profile. In addition, we see opportunities to demonstrate operating and strategic improvement as the two organizations examine how they can improve care for those in their markets. We believe management is making strides in integrating the two systems, and will continue to monitor how those events affect the overall strength of the organization over time.

Downside scenario

Although we don't expect to do so, we could lower the rating if operations become challenged for a sustained period or

if management issues significant additional debt that weakens coverage and/or debt-related ratios.

Upside scenario

Over time, we could raise the rating if AAH executes on its system strategies and can demonstrate meaningful improvement to its financial profile with financial ratios commensurate with a higher rating.

Enterprise Profile: Very Strong

Newly merged entity with expanded market position, and complementary and additive core strengths

We view AAH's market position as very healthy and sound. Key supporting areas include a broad service area across two states (with a service area population of over 12 million) in several distinct markets, a large $11 billion operating revenue base (with over 275,000 admissions), and a leading and healthy business position in most of the core markets. AAH has a full complement of inpatient and outpatient services (including tertiary and quaternary care), a wide geographic network of clinics and outpatient centers, a large employed physician and advanced practitioner base, and other post-acute-care services across the Chicagoland area, southern Illinois, and eastern Wisconsin. AAH also has a joint venture insurance plan in Wisconsin that is fairly new and is in conjunction with Anthem. We also view the increased diversification from payers (including different Medicaid programs) and from the economies of two states (and multiple markets) as a positive for the credit. While employment and per capita personal income are sound for the region, we note less population growth than the U.S. average in the service area (despite pockets of stronger growth in some of AAH's markets, particularly in Wisconsin).

Depending on AAH's ability to execute its strategies, we believe that the system could further improve its overall position in its markets by broadening its market share and patient base while improving quality and costs of care. Within the markets it operates, AAH maintains very solid and often leading market shares, though the markets remain competitive with a host of different competitors. We believe that overall, competition in the Chicago metropolitan statistical area (MSA) is increasing partly as a result of recent consolidations. Key competitors include AMITA Health (a joint venture between Adventist Midwest Health, part of Adventist Health System in Florida, and Alexian Brothers Health System, a subsidiary of Ascension Health, which recently acquired Presence Health), Northwestern Medicine, Rush University Medical Center, and the University of Chicago Medical Center. Outside the Chicago MSA, AHCN has established a limited presence in the Central Illinois market. In Wisconsin, AAH facilities compete with Ascension, Froedtert, and ProHealth in the greater Milwaukee market, as well as with Ascension, Hospital Sisters Health System, and others in the other eastern and northeastern Wisconsin markets. Consolidation and competition have increased in those markets.

We note that AAH will benefit from AHCN's pioneering and nationally known efforts as a clinically integrated network (Advocate Physician Partner) with both its employed (Advocate Medical Group) and independent physicians as well as AHC's much broader physician employment model. Both legacy entities have had success in their ACO models, so we expect them to build on that. Additionally, legacy AHCN has accepted full and partial risk (capitation) on certain commercial and Medicare advantage contracts. Both legacy systems have also managed risk through shared savings programs, including Medicare. AHC has had a history of working with employers and has also started working with

Anthem Blue Cross Blue Shield on a joint venture insurance product. We anticipate that AAH (through its employed and aligned physicians) will continue to expand its patient base under risk contracts (although incrementally) and further develop narrow network products. We believe that the differing strengths of the legacy institutions could yield benefits as AAH develops and fine-tunes its strategic focus over the next few years.

While management is very much focused on integrating the two organizations and generating synergies where appropriate, the team is also focused on moving ahead on some initial strategies while the broader team works to fully develop a more comprehensive strategic plan for AAH. In addition to moving forward on some key legacy projects (e.g., Epic implementation for legacy AHCN, and hospital projects for AHCN's Illinois Masonic Hospital and legacy AHC's Sheboygan facility), AAH will begin to pursue the development of an acute care facility on the Illinois-Wisconsin border that will be a combined effort and likely be branded as an AAH facility.

AAH continues to experience some inpatient volume growth as a result of slight market share increases and some capacity coming on line in recent years, as well as a focus on key service lines and the continued growth of employed and integrated physicians. AAH's outpatient volume also continued to improve over the past few years. Management aims to modestly increase inpatient volume (including observation visits) and outpatient volume over the next couple years. AAH continues to expand its ambulatory network, but market and industry dynamics lead us to believe that growth will likely depend on AAH's ability to capture additional market share and lives under risk-based contracts, including Medicare Advantage--although the combined AAH would likely provide new opportunities.

Management and board focus on integration and developing key strategies for the combined system

The board and management moved efficiently to have a comprehensive AAH management team in place effective the date of the merger, April 1, 2018. The overall structure of the team is largely a combination of individuals who have been at the legacy organizations, most for a number of years. We note that two co-CEOs represent legacy AHCN (Jim Skogsbergh) and legacy AHC (Dr. Nick Turkal) and that two leads from each of the legacy organizations represent the different medical groups, but the rest of the C-level positions have one lead. While the co-CEO structure could cause some challenges for the organization if decision-making slows or accountability becomes unclear, the two co-CEOs have thus far worked effectively using weekly leadership team meetings to make key decisions together. The two CEOs have known each other for a number of years and have some complementary skillsets, and the two organizations have had a joint lab business for many years as an initial introduction to each other. One key retirement for AAH is Dr. Lee Saks, who was at legacy AHCN for many years and was instrumental in the development of APP. We believe AAH has a very strong and capable management team with considerable bench strength throughout the organization and a history of financial discipline and strategic focus. We also view favorably AAH's ability to operate its legacy entities from a position of strength, particularly in a challenging state and payer environment for AHCN.

We understand that one governance team oversees AAH, evenly populated with legacy AHC and AHCN board members. While we view self-perpetuating boards as best practice, we also recognize that AAH is in its early stages and that the board has been structured to help facilitate the organization forward in the early years. We understand that the board will become self-perpetuating after the initial first four years.

As management and the board integrate and move through the strategic planning process, we expect that the new AAH management remains forward-looking on physician integration, various outpatient and clinical care strategies,

payer relationships, and integration of technology to drive improvements to the overall business. Management reports that specific clinical service line physicians are already beginning to have conversations across the system with some unique opportunities as AAH builds a hospital on the Illinois-Wisconsin border. However, management expects those broader clinical conversations to happen organically and where appropriate. While the merger of the two organizations is relatively recent, we understand that management is focused on a number of areas, including its integration plan and realizing synergies, developing an updated strategic plan for AAH, and continuing to successfully operate its legacy core entities.

Table 1

Advocate Aurora Health Enterprise Statistics

	--Three months ended March 31--	--Fiscal year ended Dec. 31--	
	2018	**2017**	**2016**
PSA population	N/A	N/A	N/A
PSA market share (%)	N/A	N/A	N/A
Inpatient admissions*	69,603	275,881	273,403
Physician hospital outpatient & other visits	3,451,345	13,504,618	13,103,801
Equivalent inpatient admissions	N.A.	N.A.	N.A.
Emergency visits	246,275	897,000	947,024
Inpatient surgeries	16,727	72,000	72,105
Outpatient surgeries	37,387	161,000	161,179
Medicare case mix index	1.7680	1.7666	1.7511
FTE employees	61,000	60,800	59,500
Employed physicians	3,500	3,397	3,081
Top 10 physicians admissions (%)	N/A	N/A	N/A
Medicare (%)§	30	30	28
Medicaid (%)§	12	12	11
Commercial/Blues (%)§	55	55	57

*Excludes normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. §Based on net revenue. FTE--Full-time equivalent. N/A--Not applicable. N.A.--Not available. PSA--Primary service area.

Financial Profile: Very Strong

Robust investment income and good operations support healthy cash flow and coverage

While both the legacy organizations contributed about the same in operating revenue to the system, legacy AHC has historically generated strong performance (in the 5%-6% range) compared with legacy AHCN (where margins have come down to 2.6% in 2017 from 3.9% in 2016 and 5.0% in 2015). On a combined basis, we view AAH's pro forma operating margins as good in recent years but note a declining trend (albeit with some one-time expenses in 2017 and interim 2018). Historically, legacy AHC has benefited from favorable payer mix as well as growth in key markets, while legacy AHCN has experienced some one-time expense restructuring efforts in 2017 along with general industry pressures over the past couple of years, including a slightly less favorable payer mix with higher governmental payers. We note that the diversity of state Medicaid revenue and synergies from the consolidation should benefit AAH. In addition, we will review the updated strategic plan as it is developed and how it may affect operations over the

medium to long term. Through interim 2018, we saw some softening in operating margins (compared with prior year) as a result of 340b cuts, AHCN's investment in Epic, timing related to distributions of clinical integration payments, some unfavorable payer mix shifts, and some one-time expenses related to the merger. However, operating income is at budgeted levels through March 2018.

Management expects AAH's fiscal 2018 operating margins to be just around 3.5% (excluding investment income from operating revenue), which we view as in line for the rating and achievable. We understand that last year's restructuring efforts (along with some volume increases) will offer support to income as the system continues to experience reimbursement stresses (including increasing governmental payers), increased expenses related to the Epic implementation, and other expense pressures related to the industry (e.g., labor, pharmaceuticals, and physician investment). We believe AAH's growth in key markets, diversification of payers, focus on increasing the number of covered lives through its managed care and risk-based contracts, and expense management will remain important to maintaining healthy cash flow and coverage. Nonoperating income should also improve as legacy AHC's unrestricted reserves are reallocated to legacy AHCN's investment allocation over the next several months. MADS coverage is smoothed for calculation purposes, with actual debt service a little more uneven with a few large bullets but some cash flow relief in the near years.

Healthy pro forma liquidity and debt-related ratios support capital spending and strategic priorities

On a pro-forma basis, unrestricted reserves declined to $7.5 billion at March 31, 2018 from $7.9 billion at Dec. 31, 2017. This decline was partly a result of weaker investment markets but also partly a result of legacy AHC's decision to acquire approximately $433 million of medical office buildings that were previously fully leased facilities. (We note that AAH excludes some of its self-insurance reserves from its unrestricted reserve calculation, and thus we believe overall cash on hand could be slightly stronger but not materially different.) While pro forma average age of plant is low (at around 9 years) and management and the board are still developing AAH's strategic plan, we expect that AAH will have a healthy capital appetite hereafter. Key near-term projects include legacy AHCN's large systemwide Epic implementation, ongoing spending at legacy AHCN's Illinois Masonic Medical Center, legacy AHC's Sheboygan replacement facility, and construction of a new AAH inpatient facility in the Racine/Kenosha market. We anticipate that AAH will spend approximately 2x annual depreciation expense in 2018 and the next couple of years and likely around 1.5x over a longer period, but will have more details as the AAH strategic plan is developed. Management reports that it will fund most capital spending through cash flow. Management continues to evaluate projects through its normal capital planning process, and we will monitor how the strategic plan and new projects may affect balance-sheet ratios.

AAH's target investment portfolio is reasonable, in our opinion, given AAH's healthy unrestricted reserves, with an allocation of about 29% equities, 45% of hedge funds, real assets, and private equity, and 22% fixed income. AAH had unfunded commitments of about $877 million for its private equity and real estate partnership investments as of Dec. 31, 2017 (to be funded over the next seven years), which we view as manageable given its $7.5 billion in unrestricted reserves. In addition, we expect that this allocation could aid investment returns for the combined entity's portfolio as legacy AHC moves its investments into the legacy AHCN's allocation.

We view AAH's pro forma debt levels as quite modest with pro forma leverage at 22% and a pro forma low debt burden of 1.6% at March 31, 2018. Despite a lack of plans to issue any debt over the next year, we understand

management continues to review and evaluate capital needs and funding.

We believe AAH's pro forma debt structure is reasonable, given its solid unrestricted reserves and investment allocation of its unrestricted reserves. More specifically, about 60% of AAH's pro forma debt is fixed, with the remainder in some type of variable-rate mode. We expect AAH to redeem the approximately $22 million of series 2008C-3B in the next few days (out of cash). The split of the remaining pro forma variable-rate debt is:

- $70 million in windows mode that provides seven months' notice before a mandatory tender would occur (2011B);
- $100 million in direct placement bonds (2011C, 2011D);
- Approximately $202 million of floating-rate notes (series 2018C); and
- $321.3 million in weekly variable-rate demand mode backed by various liquidity facilities (see below).

Specifically, the providers of the liquidity facilities of the $321.3 million of other VRDBs are:

- JPMorgan Chase Bank (series 2008C-1; 'A-1'), Aug. 31, 2020;
- Wells Fargo Bank N.A. (series 2008C-2A: 'A-1+'), Aug. 1, 2019;
- JPMorgan Chase Bank (series 2008C-2B; 'A-1'), Aug 15, 2021; and
- Northern Trust (series 2008C-3A; 'A-1+'), Aug 15, 2021.

AHCN provides liquidity support for the series 2011B windows mode variable-rate debt and the series 2008C-3B variable-rate debt, which will be paid off July 30, 2018. Based on AHCN's liquidity analysis provided to our funds group, the system can amply cover its total $92 million of its self-liquidity-backed VRDBs, in our view. (As of June 2018, AHCN had unrestricted reserves of $1.3 billion based on the funds group analysis and $865.6 million based on discounted analysis.) In addition, AAH maintains $585 million of available lines of credit for added flexibility, on which there was $58.5 million draw as of March 31, 2018 that will be paid off with the upcoming series 2018 taxable debt issuance.

In addition to the above variable-rate debt, other contingent debt includes:

- $120.3 million in long-term interest rate mode with mandatory tenders within two years (2008A-1, 2008A-2, and 2008A-3);
- $115 million of a taxable term loan held by Bank of America (which is held until maturity of 2024); and
- Approximately $202 million of series 2018B tender bonds (which will be remarketed on an ongoing basis);

Key rating and financial covenants related to the bank-held debt are maintenance of a credit rating at 'BBB' or higher and coverage of 1.1x or higher. Total pro forma contingent debt (as calculated by S&P Global Ratings and including other VRDBs) is about 39% of debt outstanding.

AAH maintains three floating- to fixed-rate swaps with a total notional amount of $326.3 million as of Dec. 31, 2017 (all legacy AHCN). The counterparties are Wells Fargo Bank and PNC Bank N.A. As of Dec 31, 2017, the liability on the swaps was lower than in previous years at $74 million with no collateral posting required.

We view AAH's defined benefit plans as being of minimal risk given the good funding levels and legacy AHCN's active plan's status a church plan. Legacy AHCN also has an ERISA plan that is frozen. Together, Legacy AHCN's plans were more than 100% funded at Dec. 31, 2017. Legacy AHC also maintains a defined benefit plan that is well funded (over 90%) and frozen to new benefits and entrants (as of 2012).

Table 2

Advocate Aurora Health Pro Forma Financial Statistics*

	--Three months ended March 31--	--Fiscal year ended Dec. 31--		'AA+' rated health care system medians	'AA' rated health care system medians
	2018	2017	2016	2017	2017
Financial performance					
Net patient revenue ($000s)	2,761,141	10,903,422	10,142,980	3,949,400	2,959,918
Total operating revenue ($000s)	2,933,532	11,672,791	10,840,732	MNR	MNR
Total operating expenses ($000s)	2,840,677	11,231,419	10,308,733	MNR	MNR
Operating income ($000s)	92,855	441,372	531,999	MNR	MNR
Operating margin (%)	3.17	3.78	4.91	5.20	3.60
Net nonoperating income ($000s)	85,350	350,698	269,882	MNR	MNR
Excess income ($000s)	178,205	792,070	801,881	MNR	MNR
Excess margin (%)	5.90	6.59	7.22	9.60	7.40
Operating EBIDA margin (%)	8.66	9.19	10.34	12.60	10.40
EBIDA margin (%)	11.24	11.84	12.52	16.20	13.50
Net available for debt service ($000s)	339,340	1,423,287	1,390,977	813,086	499,394
Maximum annual debt service (MADS; $000s)§	222,914	222,914	222,914	MNR	MNR
MADS coverage (x)	6.09	6.38	6.24	7.40	6.50
Operating-lease-adjusted coverage (x)	N.A.	4.41	4.31	5.50	4.60
Liquidity and financial flexibility					
Unrestricted reserves ($000s)	7,459,729	7,881,496	6,927,323	5,138,713	3,055,984
Unrestricted days' cash on hand	251.5	268.5	257.2	424.3	341.8
Unrestricted reserves/total long-term debt (%)	257.5	266.8	226.0	349.0	259.9
Unrestricted reserves/contingent liabilities (%)†	659.2	N/A	N/A	808.9	758.2
Average age of plant (years)	9.1	9.5	10.1	8.7	10.3
Capital expenditures/depreciation and amortization (%)	412.4	118.7	157.0	137.4	154.6
Debt and liabilities					
Total long-term debt ($000s)	2,897,150	2,954,176	3,065,441	MNR	MNR
Long-term debt/capitalization (%)	22.4	23.1	26.5	19.1	23.3
Contingent liabilities ($000s)†	1,131,625	N.A.	N.A.	MNR	MNR
Contingent liabilities/total long-term debt (%)†	39.1	N.A.	N.A.	43.8	44.1
Debt burden (%)	1.85	1.85	2.01	1.70	1.90
Defined-benefit plan funded status (%) - Legacy Aurora	N.A.	92.9	92.1	94.5	86.1

Table 2

Advocate Aurora Health Pro Forma Financial Statistics* (cont.)

	--Three months ended March 31--	--Fiscal year ended Dec. 31--		'AA+' rated health care system medians	'AA' rated health care system medians
	2018	2017	2016	2017	2017
Defined benefit plan funded status (%) - Legacy Advocate	N.A.	104.8	98.0	94.5	86.1

*Please note that pro-forma financials were compiled by management; Fiscal years 2017 and 2016 used legacy Aurora Health Care Network and Advocate Health Care audits. §Includes capital leases, loans and MTI debt but excludes the small amount of capital leases for legacy Advocate Health Care Network. †Pro forma contingent debt amounts include upcoming refinancing; numbers may change after marketing of bonds. MNR--Median not reported. N/A--Not applicable. N.A.--Not available.

Credit Snapshot

- Security: The rated bonds are the general, unsecured joint, and several obligations of the obligated group, which effective Aug. 1 will consist of the parent, AAH; AHCN; Advocate Health and Hospitals Corp., which includes most of AHCN's acute care facilities; Advocate North Side Health Network, which includes Advocate Illinois Masonic Center; Advocate Condell Medical Center; Advocate Sherman; Aurora Health Care Inc.; Aurora Health Care Metro Inc.; Aurora Health Care Southern Lakes Inc.; Aurora Health Care Central Inc. (doing business as Aurora Sheboygan Memorial Medical Center); Aurora Medical Center of Washington County Inc.; Aurora Health Care North Inc. (doing business as Aurora Medical Center Manitowoc County); Aurora Medical Center of Oshkosh Inc.; Aurora Medical Group Inc.; and Aurora Medical Center Grafton LLC.
- Group rating methodology status: The rating reflects our view of AAH's group credit profile (GCP) and the obligated group's core status in that the obligated group accounts for the vast majority of total operating income and assets of AAH. Accordingly, we rate the obligated group at the level of the AAH GCP and we used AAH's pro forma consolidated financial results.
- Credit overview: AAH operates mostly across northern Illinois and eastern Wisconsin with over 25 acute care hospitals, over 3,300 employed physicians, and numerous clinics and outpatient settings. The system also includes two ACOs, Advocate Physician Partners (a clinically integrated network), and a joint venture insurance company in Wisconsin with Anthem. AAH also includes long-term teaching affiliations with the University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University, and Midwestern University. As part of these affiliations, AAH trains about 600 residents in 31 legacy AHCN residency programs.

Ratings Detail (As Of July 27, 2018)

Illinois Finance Authority, Illinois

Advocate Hlth Care, Illinois

Illinois Finance Authority (Advocate Hlth Care) rev bnds (rmktd 7/25/2017) (Advocate Hlth Care) ser 2008C-3B dtd 07/25/2017 due 11/01/2038

Short Term Rating	A-1+	Affirmed