IOWA HEALTH SYSTEM AND SUBSIDIARIES
D/B/A UNITYPOINT HEALTH

CONSOLIDATED FINANCIAL STATEMENTS

SEPTEMBER 30, 2017

DISCLAIMER

This document is marked with a dated date and speaks only as of that dated date. Readers are cautioned not to assume that any information has been updated beyond the dated date except as to any portion of the document that expressly states that it constitutes an update concerning specific recent events speaks only as of its date. UnityPoint Health expressly disclaims any duty to provide an update of any information contained in this document.

The information contained in this document may include “forward-looking statements” by using forward-looking words such as “may”, “will”, “should”, “expects”, “believes”, “anticipates”, “estimates”, or others. You are cautioned that forward-looking statements are subject to a variety of uncertainties that could cause actual results to differ from the projected results. Those risks and uncertainties include general economic and business conditions, receipt of funding grants, and various other factors that are beyond our control.

Because we cannot predict all factors that may affect future decisions, actions, events, or financial circumstances, what actually happens may be different from what we include in forward-looking statements.

IOWA HEALTH SYSTEM AND SUBSIDIARIES
D/B/A UNITYPOINT HEALTH

CONTINUING DISCLOSURE STATEMENT
FOR THE
QUARTER ENDED SEPTEMBER 30, 2017

TABLE OF CONTENTS

SECTION 1

OVERVIEW OF UNITYPOINT HEALTH

GENERAL

Initially formed in 1994, Iowa Health System ("IHS"), an Iowa nonprofit corporation, controls, directly or indirectly, a regional health care delivery system that includes, as of September 30, 2017, fourteen Hospitals (including Blank Children's Hospital) in twelve Iowa cities, five hospitals in four Illinois cities, one hospital in Madison, Wisconsin, and approximately 1,700 patient service provider full time equivalents practicing in 102 communities (collectively, the "System").

IHS publicly operates as UnityPoint Health. The legal name of the parent remains Iowa Health System, with the UnityPoint Health name reflecting a doing business as (d/b/a). This "d/b/a" name reflects the transformation of clinical processes underway within the System and the adaptation to better address the health care needs of communities, including building a model of delivering health care that coordinates care around the patient while focusing on improving the quality of care and reducing costs. UnityPoint Health is a federally registered trademark and is intended to be the predominant name. UnityPoint Health will be referred to as the System for purposes of this document.

The System entities employ around 27,000 employees (on a full time equivalent basis) System-wide, including being the largest nonprofit workforce in the combined State of Iowa and Western Illinois area, and work toward innovative advancements to achieve the vision of delivering the Best Outcome for Every Patient Every Time. The System also provides a multitude of community benefit programs and services to improve the health of people in its communities.

The primary operations of the System are conducted through an array of nonprofit and for-profit subsidiaries controlled, directly or indirectly, by UnityPoint Health. The affiliates include Central Iowa Health System d/b/a UnityPoint Health – Des Moines, Methodist Health Services Corporation ("MHSC"), Trinity Regional Health System, Meriter Health Services, Inc. ("MHS"), St. Luke's Healthcare, Allen Health Systems, Inc., St. Luke's Health System, Inc., Trinity Health Systems, Inc., Finley Tri-States Health Group, Inc., Iowa Physicians Clinic Medical Foundation d/b/a UnityPoint Clinic, UnityPoint at Home, and Physicians Plus Insurance Corporation ("PPIC").

Corporations that own and operate hospitals are referred to as "Hospitals". The Hospitals include Central Iowa Hospital Corporation, which operates Iowa Methodist Medical Center in Des Moines, Iowa, including Blank Children's Hospital, Iowa Lutheran Hospital in Des Moines and Methodist West Hospital in West Des Moines; The Methodist Medical Center of Illinois and Proctor Hospital, both in Peoria, Illinois; Pekin Hospital in Pekin, Illinois; Trinity Medical Center, which operates Trinity Rock Island in Rock Island, Illinois, Trinity Moline in Moline, Illinois and Trinity Bettendorf in Bettendorf, Iowa; Unity HealthCare, which operates as Trinity Muscatine in Muscatine, Iowa; Meriter Hospital in Madison, Wisconsin; St. Luke's Methodist Hospital in Cedar Rapids, Iowa; St. Luke's/Jones Regional Medical Center in Anamosa, Iowa; Allen Memorial Hospital Corporation in Waterloo, Iowa; UnityPoint Health - Marshalltown in Marshalltown, Iowa; Northwest Iowa Hospital Corporation, which operates St. Luke's Regional Medical Center of Sioux City, Iowa; Trinity Regional Medical Center in Fort Dodge, Iowa; The Finley Hospital in Dubuque, Iowa; and Keokuk Area Hospital in Keokuk, Iowa.

UnityPoint Health is also the sole corporate member of Iowa Physicians Clinic Medical Foundation, d/b/a UnityPoint Clinic, a group practice which employs approximately 800 patient service provider full time equivalents in several markets in which the System operates Hospitals. UnityPoint Health has been the sole corporate member of UnityPoint Clinic since 1993, however, as a part of the consolidation of the System's employed physicians into UnityPoint Clinic and as a part of UnityPoint Health becoming a physician driven organization, UnityPoint Clinic is also recognized as an affiliate. Other employed physician groups in the System may use the name UnityPoint Clinic if they follow agreed upon standards and terms of trademark usage.

UnityPoint Health is the sole corporate member of UnityPoint at Home, which provides adult and pediatric home care services, nursing care, rehabilitation therapy, infusion therapy, palliative care, hospice, and home medical equipment services in communities across Iowa, Illinois, and Wisconsin. Its Iowa site locations include Des Moines, Fort Dodge, Sioux City, Storm Lake, Jefferson, Osceola, Waterloo, and Muscatine. Its Illinois sites are located in Moline and Quincy. Its Wisconsin location is in Madison. UnityPoint at Home works together with its affiliated UnityPoint Health physicians and hospitals to coordinate the services, support, and education necessary for patients to continue their care at home. Home care services in the System which are not a part of UnityPoint at Home may use the name UnityPoint at Home if they follow agreed upon standards and terms of trademark usage. Currently, the home care services provided in three regions are not part of UnityPoint at Home, but have agreed to these standards and thus are operating under the UnityPoint at Home name.

Through the end of the second quarter, UnityPoint Health was the sole corporate member of PPIC, a Wisconsin based for-profit corporation that contracts with business organizations and individuals, primarily in the Madison, Wisconsin area, to provide comprehensive medical care benefits. PPIC is organized as a health maintenance organization under Wisconsin statutes. The System's equity interest in PPIC was contributed to Quartz Holding as of July 1, 2017 as part of an Exchange Agreement. This transaction is further discussed in the section "Philosophy Regarding Growth".

MISSION AND PHILOSOPHY OF THE SYSTEM

The System's mission is to improve the health of the people and communities it serves, and its vision is to provide 'the best outcome for every patient every time.' The System was originally designed by the Board of Directors and management of UnityPoint Health to become an integrated health care delivery system whose hospital and physician providers would benefit from services provided jointly by and through the System. By providing a balance of hospitals, physicians and other providers, the System provides a health care delivery model for the region that is designed to match the best and most appropriate level of service to the needs of the patient.

1. PHILOSOPHY REGARDING GROWTH

The Board of Directors and senior management of UnityPoint Health believe that the System is currently of adequate size to achieve the benefits, efficiencies and quality improvements associated with the integration of several key, common functions. With the changing landscape of the healthcare delivery model and reimbursement, the Board of Directors and senior management of UnityPoint Health believe that there is value in pursuing opportunities for growth in a strategic fashion. UnityPoint Health's philosophy regarding additional acquisitions, affiliations or dispositions is to only pursue such transactions whenever, in the judgment of the Board of Directors and senior management of UnityPoint Health, the particular transaction under review would produce operating efficiencies, permit cost reductions or reductions in the rate of cost increases, improve delivery and quality of health services, extend its operations into areas not currently being served by the System, meet strategic or mission objectives of the System, or improve the overall efficiency or credit strength of the System. As part of its strategic growth plan, UnityPoint Health has discussed opportunities for affiliation or alignment with several independent physician groups and health systems.

Effective January 1, 2017, the System's subsidiary MHSC entered into an Affiliation agreement with Progressive Health Systems, Inc. ("PHS"), of Pekin, Illinois, under which PHS became a consolidated subsidiary of MHSC. PHS primarily operates Pekin Hospital, a 107-bed facility, and Pekin ProHealth, Inc., which offers primary and specialty care along with home health services. This affiliation allows for enhanced access to primary care providers and specialists in the Peoria market and expands the System's physician and hospital network in central Illinois. The affiliation was accomplished by MHSC becoming the sole member of PHS.

Effective January 1, 2017, the System entered into an Affiliation agreement with Keokuk Health Services, Inc. ("KHS"), of Keokuk, Iowa, under which KHS became a consolidated subsidiary of the System. KHS is comprised primarily of Keokuk Area Hospital and Tri-State Medical Group, which offers physician clinical services. This affiliation will help ensure the long-term future of health care services in the Keokuk area by providing KHS with access to management, operational and infrastructure support through the System while also increasing access to care and improving care coordination and patient experience. The affiliation was accomplished by the System becoming the sole member of KHS.

Effective January 1, 2017, the System's subsidiary St. Luke's Healthcare entered into an Affiliation agreement with Abbe, Inc., of Hiawatha, Iowa, under which Abbe became a consolidated subsidiary of St. Luke's Healthcare. Abbe operates a community mental health center and several other organizations focused on providing behavioral health care and aging services. This affiliation allows for the delivery of better integrated care in a more cost effective manner. The affiliation was accomplished by St. Luke's Healthcare becoming the sole member of Abbe, Inc.

On April 6, 2017, the System and its subsidiaries MHS (and MHS' subsidiary Meriter Hospital, Inc., hereafter referred to as UPH-M), UnityPoint Clinic and UnityPoint at Home (collectively, the "System Parties") entered into a Joint Operating Agreement (JOA) with University of Wisconsin Hospitals and Clinics Authority and University of Wisconsin Medical Foundation, Inc. (collectively referred to as "UW Health"). The JOA is a contractual agreement that aligns the parties' clinical operations and financial interests within a geographic region, including Dane County, Wisconsin and certain surrounding counties (the Collaboration Area). Under the JOA, the System Parties have delegated certain strategic direction making authority and control to UW Health within the Collaboration Area, including the right to approve the System Parties' operating and capital budgets. The System remains the sole corporate member of each subsidiary and MHS remains the sole corporate member of UPH-M. UPH-M and UW Health will each appoint one member of their respective Boards of Directors to serve as a non-voting liaison on the other party's Board. The System Parties maintain control over day-to-day operations in the Collaboration Area and ownership over all of their assets. The JOA grants UW Health the right of first refusal to acquire the UPH-M assets or operations upon the occurrence of certain events and to replace the System as the sole member of MHS in the event of termination of the Affiliation Agreement between the System and MHS. This JOA became effective on July 1, 2017 and allows for both organizations to better deliver timely access to needed medical care, save on capital costs that otherwise would be needed to provide such access, achieve a single standard of clinical care, improve the scope and quality of their services to the community, enhance their efficiency, and expand their effectiveness in population health and care management.

On April 6, 2017, the System signed an Exchange Agreement (hereafter referred to as the Insurance Exchange Agreement) with University Health Care, Inc. (UHC) and Gundersen Lutheran Health System (GLHS) (collectively, the Owners) under which each Owner will have a direct membership interest in Gundersen Health Plan, Inc., a Wisconsin non-stock insurance corporation (GHP) and a direct equity interest in Quartz Holding Company, a newly formed Wisconsin for-profit corporation (Quartz Holding). Prior to the transaction, UHC and GLHS also each had equity interests in Unity Health Plans Insurance Corporation, a Wisconsin stock insurance corporation (Unity). As a part of the transaction, the Owners formed Quartz Holding, a for-profit holding company, to which UHC and GLHS will contribute all of their equity interests in Unity and the System will contribute all of its equity interest in PPIC in exchange for equity interest in Quartz Holding. Immediately thereafter, Quartz Holding will contribute all of its equity interest in Unity to PPIC. As a result, at the close of the transaction, GLHS, UHC and the System will each directly own equity interests in Quartz Holding, Quartz Holding will directly own 100% of the equity of PPIC and PPIC will directly own 100% of the equity of Unity. This combination will form a more comprehensive, sustainable and

competitive health insurance organization while enhancing services to members by providing a greater choice of providers, products and plans. The transaction became effective on July 1, 2017 and the organizations are currently working on integrating operations and combining organizational strengths.

Effective May 1, 2017, the System's subsidiary Allen Health Systems, Inc. purchased the assets of Central Iowa Healthcare (CIH), a not-for-profit community health care provider in Marshalltown, Iowa. CIH operated a 49-bed acute care hospital, four primary care medical clinics and a state-of-the-art outpatient center. The transaction included payment of $11,900 for substantially all of the hospital assets, $24,000 for purchase of the outpatient center, along with the assumption of certain liabilities. The System plans to continue operating all facilitates over the immediate term, while working to stabilize the financial situation and turn around operations. A new legal organization, named UnityPoint Health - Marshalltown, was created as a result of this transaction.

2. PHILOSOPHY REGARDING PHYSICIAN ALIGNMENT

The Board of Directors and senior management of the System believe that physician alignment is paramount to the System's ability to provide quality care in the communities served. The System has implemented several key initiatives to ensure alignment with both its employed physician base as well as the independent physicians that provide care in the System's facilities.

The Physician Leadership Academy was established to provide education to practicing physicians as to how to become effective leaders. These physicians develop leadership skills during the academic program and are then asked to participate in various initiatives throughout the System to utilize the skills they have learned. Many of these initiatives have centered around quality or the shift from fee-for-service reimbursement to the management of the health of a population.

The System has organized the majority of its employed physician base under a single existing corporate structure (UnityPoint Clinic). This single reporting structure allows for better coordination and alignment of priorities in the clinical quality area. Talks continue with several other groups within the System that are not currently organized under this structure with the intention of more joining the System-wide group in the future. Physicians employed by the organization who are not a part of UnityPoint Clinic may use the UnityPoint Clinic name if they follow agreed upon standards and terms of trademark usage.

The System owns, through a designated physician licensed in Illinois, a noncontrolling interest in Quincy Physicians & Surgeons Clinic, S.C. d/b/a Quincy Medical Group ("QMG") of Quincy, Illinois. QMG is a multi-specialty physician practice group with approximately 215 providers practicing 34 specialties. QMG is also part of the System's accountable care organization. The physician relationships gained through this investment enable strong collaboration and clinical innovation between QMG and the System's affiliated physicians.

3. VALUE BASED CONTRACTING

The System is a participant in multiple Accountable Care Organizations (ACOs) that seek to increase quality, value, accountability, and coordination of care across the health care continuum. The System is the largest participant in the country in the Medicare Next Generation ACO Model Program. This program is for ACOs that are experienced in coordinating care for populations of patients and allows groups to assume higher levels of risk and reward than are available under the original Medicare Pioneer Model and Shared Savings Programs. The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Medicare beneficiaries.

In total, the ACO agreements the System is a participant in cover approximately 210,000 lives and include provisions for incentive dollars to be earned based on maintaining costs below target levels or achieving certain metrics of quality for the attributed patient population. Costs above target levels for certain of these contracts, covering approximately 120,000 lives, carry a risk of loss.

4. INSURANCE DEVELOPMENT

On January 28, 2016, the System became 50% owner of HealthPartners UnityPoint Health, Inc. (“HPUPH”), a health insurance corporation. This corporation was formed between the System and HealthPartners, Inc., a Minnesota non-profit corporation based in Minneapolis, Minnesota. HPUPH is a licensed health insurer in Iowa and Illinois who intends to offer Medicare Advantage products in select counties in Iowa and Illinois in 2017. Management of HPUPH is the responsibility of a joint management committee, having equal members from both owner organizations.

5. ORGANIZATIONAL STRUCTURE

UnityPoint Health provides a number of centralized support services to other members of the System, including strategic direction; operating and capital budget coordination and approval; payor contracting, negotiation and support; compliance; billing and collecting; executive recruiting; finance and decision support; human resource; information technology; quality and performance improvement; internal audit; legal services; physician practice management; public affairs and communications; government relations; physician services; reimbursement; supply chain contracting and procurement; system development; tax and treasury services. The design and operation of the System allows System-wide planning and centralized decision-making on topics which advantage the System as a whole while preserving adequate local control in the delivery of health care services to advantage the local markets.

6. CORPORATE GOVERNANCE

The Board of Directors of UnityPoint Health meets at least five times per year and provides overall strategy and direction for the System. The Board of Directors can establish directives relating to:

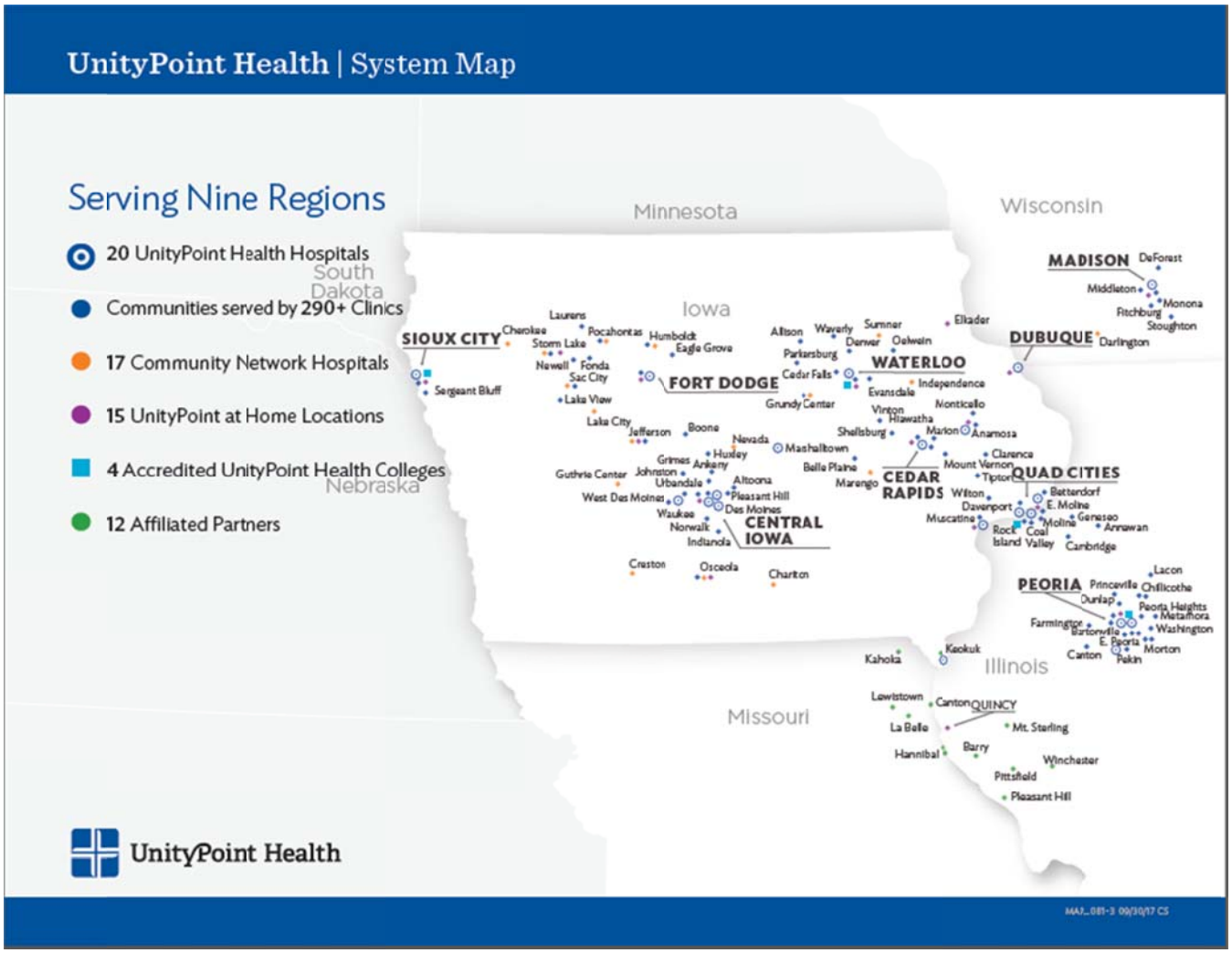
- Strategic planning
- Operating budgets
- Capital budgets
- Incurrence of indebtedness
- Managed care strategies of the System
- Transfers of assets between affiliates and other affiliates, other affiliates of UnityPoint Health, or UnityPoint Health (except to for-profit or other entities unrelated to UnityPoint Health)
- Business plans

Each affiliate, except PPIC, is required to comply with such directives and to cause the Hospitals it controls to also comply with such directives if so directed by the Board of Directors of UnityPoint Health.

In September 2003, the System's Board adopted a variety of comprehensive governance and corporate responsibility best practices. The changes include adoption of governance effectiveness guidelines on Board qualifications and fitness, guidelines for independence, outside Board service, Board roles and responsibilities, the business judgment rule, fiduciary duties, including the duties of loyalty, care, confidentiality and oversight of management, and management's access to and meetings with the Board. Board committee charters, supplementing and expanding the bylaws' descriptions of the committee's responsibilities, were adopted. Annual disclosures regarding conflicts of interest are also required under the policy. The System has continued to monitor nonprofit reform initiatives.

7. GEOGRAPHIC LOCATIONS

The following map indicates the location of various facilities of the System.



SECTION 2

CONSOLIDATED FINANCIAL STATEMENTS

UNITYPOINT HEALTH

Consolidated Balance Sheets

(in thousands)

	September 30, 2017	December 31, 2016
ASSETS	(unaudited)	(audited)
Current Assets		
Cash and cash equivalents	$ 191,058	$ 257,105
Short-term investments	18,871	13,547
Assets limited as to use - required for current liabilities	14,093	13,054
Patient accounts receivable, less estimated uncollectibles; 2017 - $86,229, 2016 - $57,582	614,998	509,899
Other receivables	133,372	85,179
Inventories	77,433	70,428
Prepaid expenses	49,126	53,318
Total current assets	1,098,951	1,002,530
Assets Limited As to Use, Noncurrent		
Held by trustee under bond indenture agreements	1,890	1,213
Internally designated	1,194,607	1,124,107
Total assets limited as to use, noncurrent	1,196,497	1,125,320
Property, Plant and Equipment, Net	1,861,477	1,804,269
Other Long-term Investments	984,636	970,821
Investments in Joint Ventures and Other Investments	152,668	140,508
Contributions Receivable, Net	90,928	87,657
Other	84,084	110,417
Total assets	$ 5,469,241	$ 5,241,522

See accompanying notes to consolidated financial statements

UNITYPOINT HEALTH
Consolidated Balance Sheets
(in thousands)

	September 30, 2017	December 31, 2016
LIABILITIES AND NET ASSETS	(unaudited)	(audited)
Current Liabilities		
Current maturities of long-term debt	$ 152,266	$ 104,474
Accounts payable	153,257	185,315
Accrued payroll	218,721	209,603
Accrued interest	5,810	10,319
Estimated settlements due to third-party payers	68,383	76,727
Medical claims payable	-	20,993
Other current liabilities	70,287	74,975
Total current liabilities	668,724	682,406
Long-term Debt, Net	1,055,989	1,063,306
Other Long-term Liabilities	413,861	419,804
Total liabilities	2,138,574	2,165,516
Net Assets		
Unrestricted		
Attributable to UnityPoint Health	3,100,574	2,856,692
Attributable to noncontrolling interest	46,524	47,642
Total unrestricted	3,147,098	2,904,334
Temporarily restricted		
Attributable to UnityPoint Health	110,323	103,638
Attributable to noncontrolling interest	917	960
Total temporarily restricted	111,240	104,598
Permanently restricted	72,329	67,074
Total net assets	3,330,667	3,076,006
Total liabilities and net assets	$ 5,469,241	$ 5,241,522

See accompanying notes to consolidated financial statements

UNITYPOINT HEALTH
Consolidated Statement of Operations
(in thousands)

Three Months Ended September 30, 2017	Three Months Ended September 30, 2016		Nine Months Ended September 30, 2017	Nine Months Ended September 30, 2016
		Unrestricted Revenues		
$ 989,975	$ 904,544	Patient service revenue (net of contractual allowances)	$ 2,899,364	$ 2,717,105
(35,404)	(34,255)	Provision for patient uncollectible accounts	(85,473)	(85,305)
954,571	870,289	Net patient service revenue	2,813,891	2,631,800
4,238	61,593	Premium revenue	132,046	184,824
68,937	59,870	Other operating revenue	244,060	172,562
2,525	2,036	Net assets released from restrictions used for operations	7,606	6,074
1,030,271	993,788	Total unrestricted revenue	3,197,603	2,995,260
		Expenses		
378,261	350,027	Salaries and wages	1,133,928	1,051,295
156,216	134,230	Provider compensation and services	458,465	407,807
138,281	84,889	Employee benefits	330,960	261,237
2,070	38,463	Medical claims and capitation payments	98,902	113,384
166,047	163,366	Supplies	490,919	470,207
161,197	160,631	Other expenses	489,682	476,556
58,880	55,094	Depreciation and amortization	174,798	165,755
9,753	8,820	Interest	28,497	24,865
314	92	Provision of uncollectible accounts	1,155	885
1,071,019	995,612	Total expenses	3,207,306	2,971,991
(40,748)	(1,824)	**Operating Income (loss)**	(9,703)	23,269
		Nonoperating Gains		
56,283	58,524	Investment income	171,547	137,921
3,629	-	Contribution received in affiliations	44,085	-
(92)	(334)	Other, net	(1,696)	(20,830)
59,820	58,190	Total nonoperating gains, net	213,936	117,091
19,072	56,366	**Revenues Over Expenses Before Loss on Bond Refinancing Transactions**	204,233	140,360
-	-	Loss on bond refinancing transactions	(19)	(22,665)
19,072	56,366	**Excess of Revenues of Expenses**	204,214	117,695
606	1,606	**Less: Noncontrolling Interest**	4,000	5,380
$ 18,466	$ 54,760	**Excess of Revenues Over Expenses Attributable to UnityPoint Health**	$ 200,214	$ 112,315

See accompanying notes to consolidated financial statements

UNITYPOINT HEALTH

Consolidated Statement of Changes in Net Assets
(in thousands)

Three Months Ended September 30, 2017	Three Months Ended September 30, 2016		Nine Months Ended September 30, 2017	Nine Months Ended September 30, 2016
		Unrestricted Net Assets		
$ 18,468	$ 54,760	Revenues over expenses	$ 200,214	$ 112,315
502	1,023	Change in the fair value on interest rate swaps	1,201	(4,510)
4,126	1,492	Net assets released from restrictions used for capital expenditures	6,141	6,554
48,229	(788)	Change in defined benefit pension plan gains (losses) and prior costs (credits)	48,229	(788)
27	-	Contributions of or for acquisition of property and equipment	145	145
(15,630)	(4,658)	Other, net	(12,048)	(5,192)
55,722	51,829	Increase in unrestricted net assets, UnityPoint Health	243,882	108,524
		Unrestricted net assets, noncontrolling interests:		
606	1,606	Revenues over expenses	3,964	5,380
(1,621)	(774)	Distributions of capital	(5,016)	(3,881)
14	14	Net assets released from restrictions used for captial expenditures	43	43
(98)	(936)	Other, net	(109)	(552)
(1,099)	(90)	Increase (decrease) in unrestricted net assets, noncontrolling interests	(1,118)	990
		Temporarily Restricted Net Assets		
32	-	Contributions received in affiliations	862	-
3,669	3,704	Contributions	8,499	13,001
937	869	Investment income	2,357	2,026
90	9	Government grants	192	57
(2,525)	(2,036)	Net assets released from restrictions used for operations	(7,606)	(6,074)
(4,126)	(1,492)	Net assets released from restrictions used for capital expenditures	(6,141)	(6,554)
1,912	699	Change in net unrealized gains on investments	5,958	452
126	3,004	Change in beneficial interest in net assets of affiliate	2,508	3,150
379	(682)	Other, net	56	(2,494)
494	4,075	Increase in temporarily restricted net assets, UnityPoint Health	6,685	3,564
		Temporarily restricted net assets, noncontrolling interests:		
(14)	(14)	Net assets released from restrictions used for capital expenditures	(43)	(43)
(14)	(14)	Decrease in temporarily restricted net assets, noncontrolling interests	(43)	(43)
		Permanently Restricted Net Assets		
57	-	Contributions received in affiliations	75	-
675	2,245	Contributions	1,711	3,077
120	(38)	Investment income (loss)	51	(99)
80	888	Change in net unrealized gains on investments	260	1,465
363	(772)	Change in beneficial interest in net assets of affiliate	2,305	(169)
(380)	1,010	Other, net	853	3,717
915	3,333	Increase in permanently restricted net assets	5,255	7,991
56,018	59,133	**Increase in Net Assets**	254,661	121,026
3,274,649	2,957,009	**Net Assets, Beginning of Period**	3,076,006	2,895,116
$ 3,330,667	$ 3,016,142	**Net Assets, End of Period**	$ 3,330,667	$ 3,016,142

See accompanying notes to consolidated financial statements

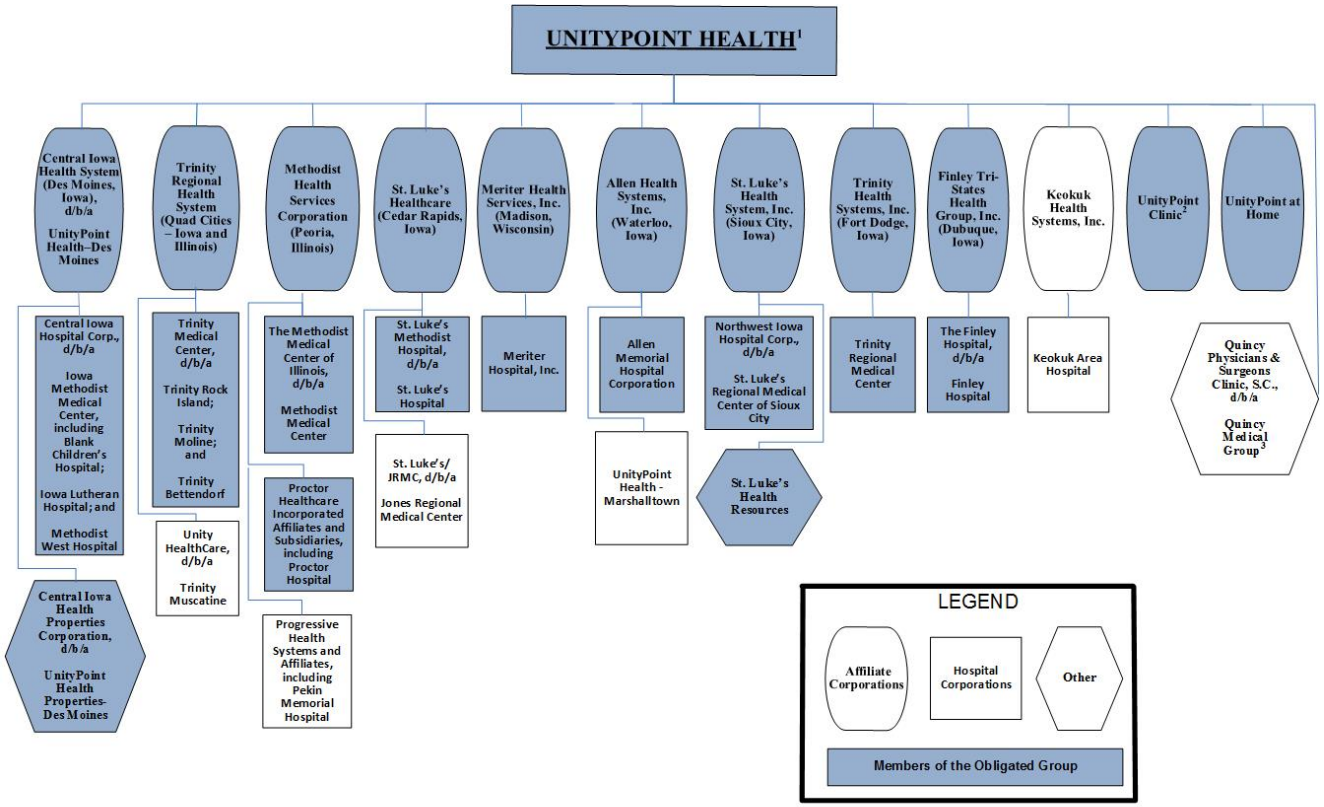
UNITYPOINT HEALTH
Consolidated Statements of Cash Flows
(in thousands)

Three Months Ended September 30,			Nine Months Ended September 30,	
2017	**2016**		**2017**	**2016**
		Operating Activities		
$ 56,018	$ 59,133	Increase in net assets	$ 254,661	$ 121,026
		Items not requiring (providing) operating cash		
(52,664)	(1,587)	Net gains on investments	(166,967)	(78,198)
(800)	(2,239)	Net unrealized (gains) losses on swaps	(3,494)	18,612
(1,330)	(4,753)	Restricted contributions, investment income and government grants received	(3,568)	(11,988)
(27)	-	Contributions of or for acquisition of property and equipment	(145)	(145)
58,880	55,094	Depreciation and amortization	174,798	165,755
(4,260)	788	Contribution received in affiliations	(49,848)	788
(482)	(450)	Amortization of bond premium and debt issuance costs, net	(1,469)	(1,042)
(535)	(1,134)	(Gain) loss on disposition of assets	(42)	310
-	-	Loss on bond refinancing transactions	19	4,346
(8,084)	(6,445)	Equity in earnings of joint ventures	(22,842)	(21,778)
(489)	(2,232)	Change in beneficial interest in net assets of affiliates	(4,813)	(2,981)
35,718	34,347	Provision for uncollectible accounts	86,628	86,190
		Change in:		
(91,768)	(19,056)	Receivables	(214,690)	(116,823)
24,454	(3,991)	Inventories, prepaid expenses, and other assets	32,035	(139)
20,014	(34,410)	Accounts payable, accrued liabilities, and other liabilities	(32,008)	(49,893)
7,945	7,264	Due to third-party payers	(11,979)	(9,380)
(5,639)	80,329	Net cash provided by operating activities	(11,953)	104,660
		Investing Activities		
(51,250)	(58,259)	Capital expenditures	(153,567)	(181,981)
448	213	Proceeds from sale of assets	722	1,153
(10,462)	(12,130)	(Increase) Decrease in assets limited as to use, net	17,090	(18,125)
58	-	Cash acquired in affiliations	13,302	-
-	-	Acquisitions, net of cash aquired	(38,948)	-
2,250	(18)	(Increase) decrease in short-term investments	(1,836)	49,018
34,421	(41,011)	(Increase) decrease in other long-term investments	72,261	32,240
(760)	(7,002)	Investments in joint ventures	(2,068)	(7,302)
6,761	20,914	Distributions received from joint ventures	17,657	31,971
(18,534)	(97,293)	Net cash used in investing activities	(75,387)	(93,026)
		Financing Activities		
2,066	-	Proceeds from issuance of long-term debt and lines of credit	60,617	512,183
(15,831)	(18,698)	Payments of debt	(40,343)	(47,592)
-	(459)	Payments of financing costs	-	(2,765)
-	-	Payments on early extinguishment of debt	(2,694)	(402,705)
1,330	4,753	Proceeds from restricted contributions, investment income and government grants	3,568	11,988
27	-	Proceeds from contributions for acquisition of property and equipment	145	145
(12,408)	(14,404)	Net cash provided by (used in) financing activities	21,293	71,254
(36,581)	(31,368)	**Increase (Decrease) in Cash and Cash Equivalents**	(66,047)	82,888
227,639	295,523	**Cash and Cash Equivalents, Beginning of Period**	257,105	181,267
$ 191,058	$ 264,155	**Cash and Cash Equivalents, End of Period**	$ 191,058	$ 264,155

See accompanying notes to consolidated financial statements

1. ORGANIZATION

The System provides inpatient and outpatient care and physician services from its hospital facilities and various ambulatory service and clinic locations in Iowa, Illinois, and Wisconsin. Primary, secondary and tertiary care services are provided to residents of these states and adjacent states. Through September 30, 2017, the System also operated a managed care insurance plan in the Madison, Wisconsin market. Members of the System, as well as designation of those that are part of the Obligated Group, are shown below:



[1] UnityPoint Health and logo is a registered trademark of Iowa Health System, d/b/a UnityPoint Health.

[2] UnityPoint Clinic is a d/b/a of Iowa Physicians Clinic Medical Foundation, an Iowa nonprofit corporation and a Tax Exempt Organization.

[3] UnityPoint Health, through a physician designee, owns or controls 45% of the stock of Quincy Physicians & Surgeons Clinic, S.C., d/b/a Quincy Medical Group, an Illinois service corporation.

This chart reflects the primary entities which provide, directly or indirectly, patient care or insurance services. All are controlled by UnityPoint Health, except for Quincy Medical Group. This chart does not reflect all UnityPoint Health controlled entities.

09-30-2017

2. BASIS OF PRESENTATION

The consolidated financial statements include the accounts of UnityPoint Health and its subsidiaries listed below:

- Central Iowa Health System and subsidiaries (d/b/a UnityPoint Health - Des Moines) (Des Moines)
- Methodist Health Services Corporation and subsidiaries (Peoria)
- Trinity Regional Health System and subsidiaries (Rock Island)
- Meriter Health Services, Inc. and subsidiaries (Madison)
- St. Luke's Healthcare and subsidiaries (Cedar Rapids)
- Allen Health Systems, Inc. and subsidiaries (Waterloo)
- St. Luke's Health System, Inc. (Sioux City)
- Trinity Health Systems, Inc. and subsidiaries (Fort Dodge)
- Finley Tri-States Health Group, Inc. and subsidiaries (Dubuque)
- Keokuk Health Systems, Inc. and subsidiaries (Keokuk)
- Iowa Physicians Clinic Medical Foundation (d/b/a UnityPoint Clinic)
- UnityPoint at Home (formerly known as InTrust and formerly d/b/a Iowa Health Home Care)
- Physicians Plus Insurance Corporation (Madison) (divested as of July 1, 2017)

As a result of the Insurance Exchange Agreement, PPIC is no longer a consolidated subsidiary of the System. Revenue and expense detail for the period of the year prior to the date of divestiture remain included in the nine months ended September 30, 2017 consolidated statement of operations. All significant intercompany balances and transactions have been eliminated in consolidation. The System's significant accounting policies conform with health care industry practices generally accepted in the United States of America.

3. USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements as well as the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

4. EXCESS OF REVENUES OVER EXPENSES

Excess of revenues over expense transactions affecting unrestricted net assets are reflected in the consolidated statements of operations. Consistent with industry practice, the effective portion of derivative instruments carried at fair value and qualifying for hedge accounting, change in defined benefit plans, as well as contributions of long-lived assets (including assets acquired with donor-restricted cash contributions) are excluded from determination of the excess of revenues over expenses. Transactions related to temporarily or permanently restricted net assets are recorded as additions or deductions to net assets and reflected in the consolidated statements of changes in net assets.

5. INVESTMENTS AND INVESTMENT RETURN

The System engages an investment advisor to manage the majority of investments in a pooled portfolio. The advisor utilizes a manager-of-managers approach through the use of proprietary registered mutual funds. Investments consist primarily of interests in registered mutual funds, which in turn invest in marketable securities. Additionally, the System holds ownership interest in various alternative investment vehicles, which consist of five alternative funds, one hedge fund, and two private equity fund. There is no public market for shares in these alternative investment vehicles. The value of the investments in the funds is determined based on the fair values of the underlying securities.

All investments are included in either assets limited as to use or other long-term investments in the consolidated balance sheets. The investment strategy of the alternative investment vehicles vary, but center around providing low return volatility through tactical investment strategies while earning a total rate of return in excess of rates achieved from a standard index.

Assets limited as to use include amounts held by trustees under bond indenture agreements and related documents, assets internally designated by the Board of Directors for identified purposes and over which the Board of Directors retains control and may, at its discretion, subsequently use for other purposes and assets held in custody by government agencies under statutory reserve. Amounts required to meet current liabilities are classified as current assets.

Investments in marketable securities with readily determinable fair values and all investments in fixed income securities are measured at fair value in the consolidated balance sheets. The fair values are based on quoted market prices or dealer quotes.

Investments in joint ventures and other affiliates, which are more than 20% but not more than 50% owned, are recorded using the equity method. Other investments are reported at cost, as adjusted for permanent impairment in value, if any.

Investment return includes interest and dividend income, realized and unrealized investment gains and losses, and earnings from investments accounted for under the equity method. Investment return, except any portion earned as a function of operations, is reported as non-operating gains (losses) and is included in revenues over expenses, unless investment return is restricted by donor or law.

6. INVESTMENT ALLOCATION

The System operates a Capital Pool Investment Program (the "Program") to manage, on a centralized basis, certain excess operating funds of the System. The Investment Committee of the System oversees the Program and establishes investment policies and guidelines that address asset allocation, diversification requirements, credit rating requirements and prohibited transactions and securities.

The Program is managed by professional investments managers, subject to the performance standards and asset allocation guidelines established in the Program. Under these guidelines, funds are invested primarily in registered mutual funds, which in turn invest in marketable securities, five alternative funds, one hedge fund, and two private equity funds.

At September 30, 2017 and December 31, 2016, 24% and 23%, of the System's investments were invested in alternative investment vehicles. Substantially all of the remainder are invested in registered mutual funds. Due to the nature of the alternative investments and the need for the fund managers to execute on long-term strategies, many of the vehicles contain specific lock-up periods, restricted redemption timing, as well as advanced notice of redemption requests.

7. NET PATIENT SERVICE REVENUE AND ACCOUNTS RECEIVABLE

Net patient service revenue is reported at the estimated net realizable amount primarily from patients and third-party payers for services provided, including retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period in which the related services are provided, and adjusted in future periods as final settlements are determined. The system recognizes patient service revenue in the period the services are provided on the basis of contractual or standard rates for services provided less a provision for uncollectible accounts.

Patient accounts receivable are stated at net realizable value. The receivables are netted down for allowances based on contractually due amounts as well as a provision for uncollectible accounts. The difference between the standard rates (or the discounted rates if negotiated or provided by policy) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts. In evaluating the collectability of accounts receivable, the System analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for uncollectible accounts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts.

Patient service revenues at established rates less third-party payer contractual adjustments (but before the provision for uncollectible accounts), recognized for the nine months ended September 30, were approximately:

	2017	2016
Medicare	$ 968,632	$ 899,169
Medicaid	416,767	405,834
Wellmark	620,786	568,539
Commercial and other	842,229	790,582
Self-pay	50,951	52,981
	$ 2,899,365	$ 2,717,105

Patient accounts receivable at established rates, less contractual allowances and the provision for uncollectible accounts, by payer class at September 30, 2017 and December 31, 2016 were as follows:

	2017	2016
Medicare	$ 187,533	$ 143,323
Medicaid	104,982	72,574
Wellmark	100,746	84,965
Commercial and other	210,602	191,252
Self-pay	11,125	17,785
	$ 614,988	$ 509,899

8. PREMIUM REVENUE

Premium revenue is billed in advance of its respective coverage periods. Those billings are recorded as deferred premium revenue until the month of coverage, at which time they are recognized as revenue in accordance with the terms of the contracts.

9. MEDICAL CLAIMS AND CAPITATION PAYMENTS

Medical claims and capitation payments consist of fixed contractual payments to providers (net of coordination of benefits and subrogation recoveries) and premiums paid for reinsurance (net of reinsurance recoveries). In exchange for monthly capitation payments, PPIC has an agreement with an unrelated organization to assume a portion of the responsibility for certain medical and professional services to covered members enrolled in the organization's plan in PPIC's primary service area, Dane County, Wisconsin.

Claims payable result from both claims reported but not paid and claims that have been incurred but not yet reported. Such liabilities are based on assumptions and estimates, and while management believes the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed, and any adjustments are reflected in the period determined.

10. UNCOMPENSATED CARE

The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. The policy provides a percentage discount to the patient that decreases at gradually higher income levels or higher levels of household net assets. The benchmark upon which the income level is compared to is the Federal Poverty Income Guideline and is updated annually. Patients who are already receiving benefits from certain identified government programs qualify for presumptive eligibility.

The availability of charity care is widely communicated to all patients and patients are notified prior to receiving services if their treatment does not fall within the guidelines of the policy. Amounts charged for care that is provided to individuals eligible for charity may not be more than the amounts generally billed to individuals who have insurance covering such care. Amounts billed are based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

Accounts that are classified by the System as charity care are not reported as net patient service revenue. For the nine months ended September 30, 2017 and 2016, the System's charity care provided was $62,010 and $46,002 respectively. In some cases, the charity care is subsidized by contributions from volunteer organizations or other donors.

Uncompensated care is also provided through reduced price services and free programs offered throughout the year. The System provides an array of uncompensated activities and services intended to meet community health needs. These activities include wellness programs, community education programs, and various health screening programs. The cost of providing these community benefit services is reported on Schedule H of the System's IRS Form 990.

11. THIRD-PARTY REIMBURSEMENT

As a provider of health care services, the System generally grants credit to patients without requiring collateral or other security. The System routinely obtains assignments of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans or policies. These health insurance programs or providers are commonly referred to as third-party payers and include the Medicare and Medicaid programs, Wellmark and various health maintenance and preferred provider organizations.

A major portion of the System's revenues are derived from these third-party payers. Significant changes have been made, and may be made, in certain of these programs, which could have a material, adverse impact on the financial condition of the System. These changes include federal and state laws and regulations, particularly those pertaining to Medicare and Medicaid.

The System has agreements with certain third-party payers that provide for payment of services at amounts different from established rates. Third-party payer payment rates vary by payer and include established charges; contracted rates less than established charges; prospectively determined rates per discharge, per procedure, or per diem; and retroactively determined cost-based rates.

12. MEDICAID STATE PLANS

The System has operations within states that have enacted a Medicaid State Plan. Under each of these plans, a tax assessment is levied on certain hospital providers in order to provide funding for Medicaid to obtain federal matching funds. A portion of these additional federal funds are then redistributed to participating hospitals through increased Medicaid payments in order to help bring Medicaid reimbursement closer to the cost of providing care. The allocation of these funds to specific health care providers is based primarily on the amount of care provided to Medicaid recipients.

The System's aggregate tax assessment during 2017 and 2016 was $41,161 and $39,034, respectively, and is included in operating expenses in the consolidated statements of operations. Additional Medicaid reimbursement in the same periods was approximately $95,225 and $93,694, respectively, and is included in net patient service revenue in the consolidated statements of operations, resulting in a net increase in operating income of $54,064 and $54,660 for 2017 and 2016, respectively. This increase is mainly the result of Medicaid expansion in the states in which the System operates, leading to a higher level of Medicaid beneficiaries, and thus increases in the money received from these programs.

13. CONTRIBUTIONS AND INTEREST IN NET ASSETS

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by the donor. Donor-imposed restrictions are considered fulfilled as soon as the stipulated time has expired or the qualifying expenditure has been made. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

Contributions not expected to be collected within a year are recorded at the present value of expected future cash flows using a risk-free interest rate over the term of the contribution. Contributions of property are recorded at fair value when received.

Interest in charitable trusts and perpetual trusts is carried at the present value of expected future cash flows. The System's interest in the net assets (the "Interest") of certain foundations that raise and hold assets on behalf of the System is accounted for in a manner similar to the equity method. The Interest is stated at fair value, and changes in the Interest are included in the change in net assets. Transfers of assets between these foundations and the System are recognized as increases or decreases in the Interest.

14. ESTIMATED MALPRACTICE COSTS, HEALTH INSURANCE AND WORKERS' COMPENSATION

An annual estimated provision is accrued for the self-insured portion of medical malpractice, health insurance and workers' compensation claims and includes an estimate of the ultimate costs for both reported claims and claims incurred but not reported.

15. RISK MANAGEMENT

The System's Hospitals are primarily self-insured for professional and general liability for amounts of $5,000 per claim ($3,000 per claim for MHSC) and $30,000 in the aggregate annually. Other entities of the System maintain their professional and general liability coverage on a claims-made basis with no significant deductibles.

The System is primarily self-insured for workers' compensation and employee health care claims. Workers' compensation claims individually and in the aggregate that exceed certain amounts are covered by insurance.

Property insurance is maintained with at least 90% replacement value coverage and minimal deductibles. Network security and information privacy insurance as well as business interruption insurance coverage is also maintained by the System.

The System has accrued as other liabilities $102,839 and $101,129 for self-insured losses at September 30, 2017 and December 31, 2016, respectively. These liabilities are presented on a gross basis and any expected offsetting insurance recoveries are reported as a receivable. The accrued liabilities are based on management's evaluation of the merits of various claims, historical experience and consultation with external insurance consultants and actuaries, and include estimates for incurred but not reported claims. There can be no assurance that the accrued liabilities will be sufficient for the ultimate amounts that will be paid for claims and settlements. Also, in the ordinary course of business, the System is involved in other litigation and claims, none of which management believes will ultimately result in losses that will adversely affect the System's consolidated net assets or results of operations to a material degree.

Cash and investments have been internally designated to be held for payments of claims, if any, which may result from the self-insured or uninsured portion of liability insurance and workers' compensation claims. At September 30, 2017 and December 31, 2016, the cash and investments amounted to $35,886 and $32,233, respectively.

16. LONG-TERM DEBT

Long-term debt at September 30, 2017 and December 31, 2016 is summarized as follows:

	Payable Through	Interest Rate	Sept 30, 2017	December 31, 2016
Hospital Facility Revenue Bonds				
Series 2016A	2035	Variable	86,230	90,010
Series 2016B	2041	Variable	51,220	51,220
Series 2016C	2031	Variable	10,430	10,935
Series 2016D	2046	Fixed	44,100	45,820
Series 2016E	2046	Fixed	168,690	172,100
Series 2016F	2041	Variable	42,500	42,500
Series 2016G	2041	Variable	42,500	42,500
Series 2014A (WHEFA)	2029	Fixed	78,125	78,125
Series 2014A	2019	Variable	7,559	7,892
Series 2014B	2018	Variable	1,900	1,973
Series 2014C	2035	Fixed	69,145	69,145
Series 2013A	2044	Fixed	103,175	103,175
Series 2013B	2039	VRDB	75,255	76,350
Series 2012A	2024	Fixed	12,400	12,400
Series 2012C	2037	Fixed	18,255	18,255
Series 2011A	2021	Fixed	31,280	31,280
Series 2011	2031	Fixed	456	486
Series 2009D	2035	Variable	46,045	48,065
Series 2009E	2039	Variable	38,100	38,100
Series 2005	2031	Fixed	2,890	3,030
Series 2005A	2035	Fixed	87,690	94,575
Series 1992A	2022	Fixed	5,510	5,510
Total hospital facility revenue bonds			1,023,455	1,043,446
Capital lease obligations	2026	Fixed	16,522	18,743
Commercial paper	Ongoing	Variable	80,141	35,496
Revolving lines of credit	2017	Variable	29,500	28,000
Other notes and mortgages	2022	Fixed	31,305	12,635
			1,180,923	1,138,320
Current maturities			(152,266)	(104,474)
Unamortized bond issuance costs			(7,527)	(7,291)
Unamortized bond premium			34,859	36,752
Long-term portion			1,055,989	1,063,307

Aggregate remaining maturities of long-term debt are as follows:

Oct 2017 - Sept 2018	152,266
Oct 2018 - Sept 2019	39,769
Oct 2019 - Sept 2020	28,116
Oct 2020 - Sept 2021	48,424
Oct 2021 - Sept 2022	39,052
Thereafter	873,296
	$ 1,180,923

The Series 1992A, 2012A and 2012C Bonds were issued by MHS prior to their affiliation with the System, and thus they were the sole obligor under the bond indenture. In May 2014, MHS and Meriter Hospital, a subsidiary of MHS, became members of the System's obligated group of joint and severally liable parties to the System's master trust indenture. As a result of this transaction, the System and obligated group became additional obligors to the Series 1992A, 2012A and 2012C Bonds.

The Series 1998 bonds were issued by KHS prior to their affiliation with the System, and thus they are the sole obligor under the bond indenture. These bonds carry certain covenants and default provisions, including a debt service coverage ratio requirement. This ratio is not currently being met; however, this does not constitute an event of default due to the compliance with certain provisions of the bond agreement.

The Series 2011 Bonds are obligations of one of the System's subsidiaries that were issued prior to their affiliation. The proceeds were used to refund a prior outstanding bond, repay a construction line-of-credit, and fund the remainder of the facility addition. The bond is secured by a first mortgage lien on the facility and a security interest in certain personal property, machinery and equipment. The amount outstanding as of September 30, 2017 and December 31, 2016, was $456 and $486, respectively.

On May 21, 2014, the System issued $174,380 of Wisconsin Health and Educational Facilities Authority (WHEFA) Revenue Bonds, Series 2014A and Series 2014B, to refinance debt held by MHS prior to the affiliation and $69,145 of Iowa Finance Authority Health Facilities Revenue Bonds, Series 2014C, to refund a portion of the Series 2005A bonds. The Series 2014B Bonds were refunded with the issuance of direct note obligations, Series 2016F, during 2016 (see below).

In August 2014, one of the System's subsidiaries issued tax-exempt Hospital Revenue Bonds, Series 2014A, with an aggregate principal amount not to exceed $8,250 and taxable Hospital Revenue Bonds, Series 2014B, with an aggregate principal not to exceed $2,750 through the City of Anamosa, Iowa, to finance a renovation and expansion capital project. Amounts are only reflected as a liability as funds are drawn down. The amounts outstanding for Series 2014A Bonds as of September 30, 2017 and December 31, 2016 were $7,559 and $7,892, respectively. The amounts outstanding for Series 2014B Bonds as of September 30, 2017 and December 31, 2016 were $1,900 and $1,973, respectively.

On January 4, 2016, the System issued $93,610 of direct note obligations, Series 2016A, to refund the Series 2009A and Series 2009B Bonds. On January 22, 2016, the System issued $11,410 of direct note obligations, series 2016C, to refund the series 2006 Bonds. On February 8, 2016, the System issued $51,220 of direct note obligations, Series 2016B, to refund the Series 2011B Bonds. The Series 2016A, 2016B and 2016C Bonds removed the requirement to maintain letters of credit set to expire in 2016.

On June 7, 2016, the System issued $45,820 of Illinois Finance Authority Revenue Bonds, Series 2016D, to refund the Series 2006A bonds and finance various capital projects and $176,770 of Iowa Finance Authority Revenue Bonds, Series 2016E, to refund the Series 2008A bonds and finance various capital projects.

On June 8, 2016, the System issued $85,000 of direct note obligations, Series 2016F and Series 2016G, to refund the Series 2014B (WHEFA) bonds, which had a mandatory tender date in 2016.

The Series 2016D, 2016E, 2013A, 2013B, 2011A, 2010A, 2009D, 2009E, 2005 and 2005A Bonds (collectively “the Bonds”) and the Series 2016A, 2016B, 2016C, 2016F and 2016G direct note obligations (collectively “the Notes”) are general obligations of the System and its affiliates. The System is required to meet certain operating and financial ratios contained in the master bond trust indenture, bond insurance agreements and bank letter of credit agreements (related to the variable rate demand bonds). The Bonds and Notes are subject to the provisions of amended and restated master trust indentures, which generally require monthly or quarterly deposits for principal and interest payments be made, and certain funds be maintained by the trustee for interest payment and bond retirement purposes. The Bonds and Notes are secured by the System’s revenues.

The variable interest rates on substantially all of the bonds are adjusted daily or weekly by remarketing agents. The bonds may be tendered by the bond holders each interest rate period. The System maintains a letter of credit that can be drawn on should the Series 2013B variable rate demand bonds not be remarketed. This letter of credit expires in 2020 and is renewable, subject to trustee approval and at the option of the providers, through the term of the bonds. All other variable rate demand bonds with letters of credit set to expire in 2016 were refunded and removed the requirement to maintain letters of credit. Outstanding amounts under the letters of credit are due at the earlier of expiration of the agreement or over a period of three years, commencing after an initial outstanding period of 366 days or more.

On December 1, 2014, the System established a $200,000 taxable commercial paper program, which had $91,653 drawn on it as of June 30, 2017. The System’s commercial paper program is sold in traunches, with varying maturities of one to 270 days, so that no more than $25,000 will mature in any five business day period.

In 2012, the System entered into two separate revolving line of credit facilities that provide for revolving credit in an aggregate principal amount of up to $50,000 each. The interest rates applicable to loans under the credit agreements are based on LIBOR plus certain margins, as defined in the agreements. Additionally, the facilities carry a commitment fee, which is charged on the average daily undrawn portion of the facilities. These credit facilities mature in 2018. These agreements contain various financial covenants that mirror those in the System's master bond trust indenture.

17. INTEREST RATE SWAP AGREEMENTS

The System has entered into various interest rate Swap Agreements (the "Swaps" or "Swap Agreements") to reduce the effect of changes in cash flows primarily related to interest rate fluctuations on the System's various variable rate debt.

The System has designated certain Swaps as hedges, while other Swaps have not been designated as hedging instruments. The effective portion of changes in the fair value of Swaps designated as hedges is recognized as a component of other changes in net assets, while the ineffective portion of these Swaps changes in fair value, and all changes in fair values of Swaps not designated as hedges, is recorded as a component of nonoperating gains (losses) in excess of revenues over expenses.

The Swaps are recognized in the consolidated balance sheets at fair value. The net cash payments or receipts under the Swaps designated as hedging instruments are recorded as an increase or decrease to interest expense. The net cash payments or receipts under the Swaps not designated as hedges are recorded as an increase or decrease to other nonoperating income (loss).

The following tables summarize the currently outstanding Swaps:

Swaps Designated as Hedging Instruments

The aggregate fair value of the Swap Agreements at September 30, 2017 and December 31, 2016 is recorded as a long-term liability of ($16,056) and ($16,897), respectively.

Maturity Date	Current Notional Amount	System Pays	System Receives	Counterparty	Accounting Treatment	Fair Value 9/30/2017	Fair Value 12/31/2016
2035	$ 104,700	3.48%	62.4% of 3m LIBOR + 29 bps	JP Morgan	Cash Flow Hedge	$ (16,056)	$ (16,897)
						$ (16,056)	$ (16,897)

Other Swap Agreements

The aggregate fair value of the Swap Agreements at September 30, 2017 and December 31, 2016 are recorded as long-term investments of $962 and $681 and long-term liabilities of ($50,527) and ($53,041), respectively.

Maturity Date	Current Notional Amount	System Pays	System Receives	Counterparty	Accounting Treatment	Fair Value 9/30/2017	Fair Value 12/31/2016
2030	60,000	100% of SIFMA	68.0% of 10Y LIBOR + 14.3 bps	Morgan Stanley	Non-Hedge	962	681
2037	132,000	3.8%	61.9% of 1m LIBOR + 31 bps	Morgan Stanley/Union	Non-Hedge	(32,639)	(33,585)
2026	19,600	3.5%	63.0% of 1m LIBOR + 30 bps	Morgan Stanley/Piper Jaffray	Non-Hedge	(1,787)	(2,066)
2024	12,400	3.5%	63.0% of 1m LIBOR + 30 bps	Morgan Stanley/Piper Jaffray	Non-Hedge	(883)	(1,079)
2023	37,800	3.5%	61.9% of 1m LIBOR + 31 bps	Morgan Stanley/Deutsche Bank	Non-Hedge	(3,573)	(4,108)
2032	23,500	3.5%	67.0% of 1m LIBOR	U.S. Bank	Non-Hedge	(4,435)	(4,599)
2035	52,350	3.3%	62.4% of 1m LIBOR + 29 bps	Deutsche Bank	Non-Hedge	(7,210)	(7,604)
						$ (49,565)	$ (52,360)

18. COMMITMENTS AND CONTINGENCIES

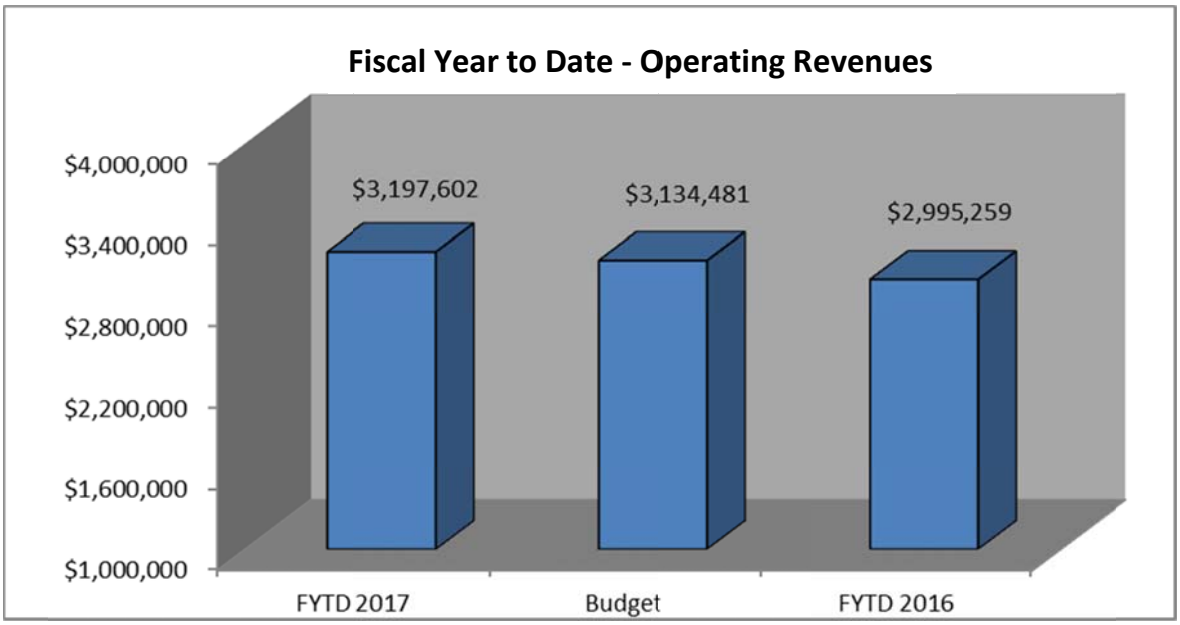
The health care industry is subject to numerous laws and regulations of federal, state and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in the imposition of significant fines and penalties as well as significant repayments of previously billed and collected revenues for patient services. The System has a corporate compliance plan intended to meet federal guidelines. As a part of this plan, the System performs periodic internal and external reviews of its compliance with laws and regulations. As part of the System's compliance efforts, the System investigates and attempts to resolve and remedy all reported or suspected incidents of material noncompliance with applicable laws, regulations or policies on a timely basis. The System believes that these compliance programs and procedures lead to substantial compliance with current laws and regulations.

The System is in various stages of responding to inquiries and investigations. These various inquiries and investigations could result in fines and/or financial penalties. At this time, the System is unable to estimate the possible liability, if any, that may be incurred as a result of these inquiries and investigations, but the System does not believe it would materially affect the financial position of the System.

SECTION 3

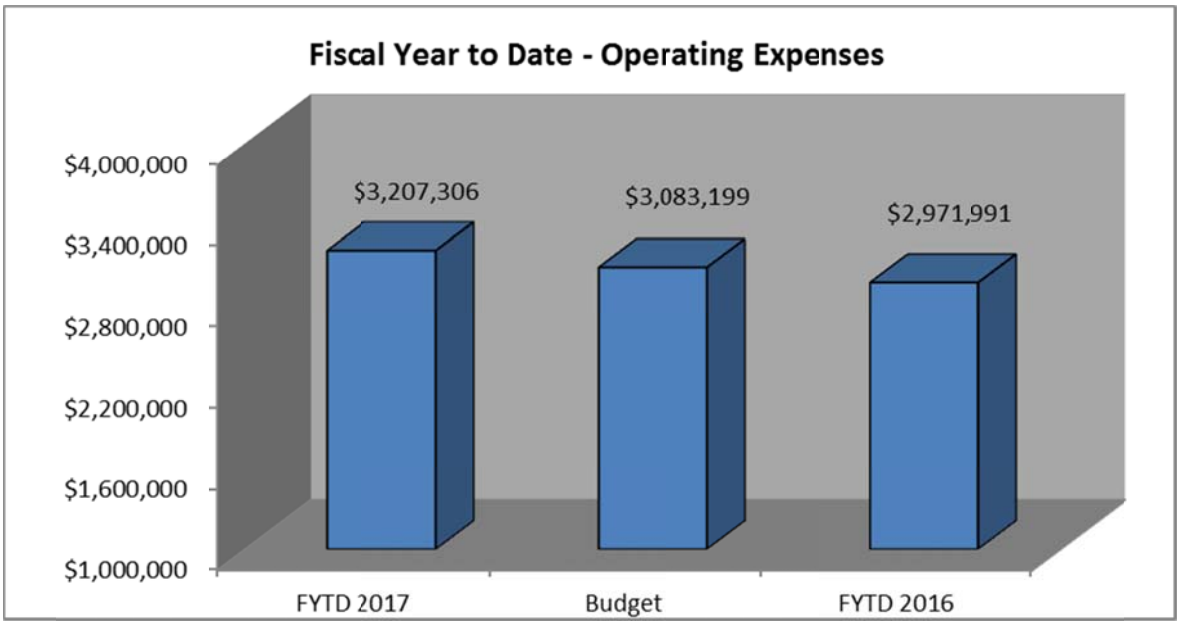
MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL RESULTS

1. Revenues



Total operating revenues have increased by 6.8% for the nine months ended September 30, 2017 compared to the same time period in 2016. Affiliation transactions with five new organizations occurred during the year, contributing $120.0 million of incremental revenue year over year. Excluding these, operating revenues increased 2.7% compared to 2016. Actual operating revenues were favorable to budget by 2.0% for the nine months ended September 30 and fell short budget by 1.8% when excluding the new and unbudgeted affiliations. The budget shortfall, when excluding the unbudgeted affiliations, is due to the divestiture of PPIC at the end of the second quarter. Excluding the budgeted revenue of PPIC, operating revenues, less the incremental amount from unbudgeted affiliations, were favorable to budget by $6.2 million, or 0.2%. Also excluding these affiliations, inpatient discharges, excluding newborns, were unfavorable to budget by 0.7% and adjusted discharges (which take into account the impact of hospital outpatient activity) were 1.4% unfavorable to budget for the nine months ended September 30.

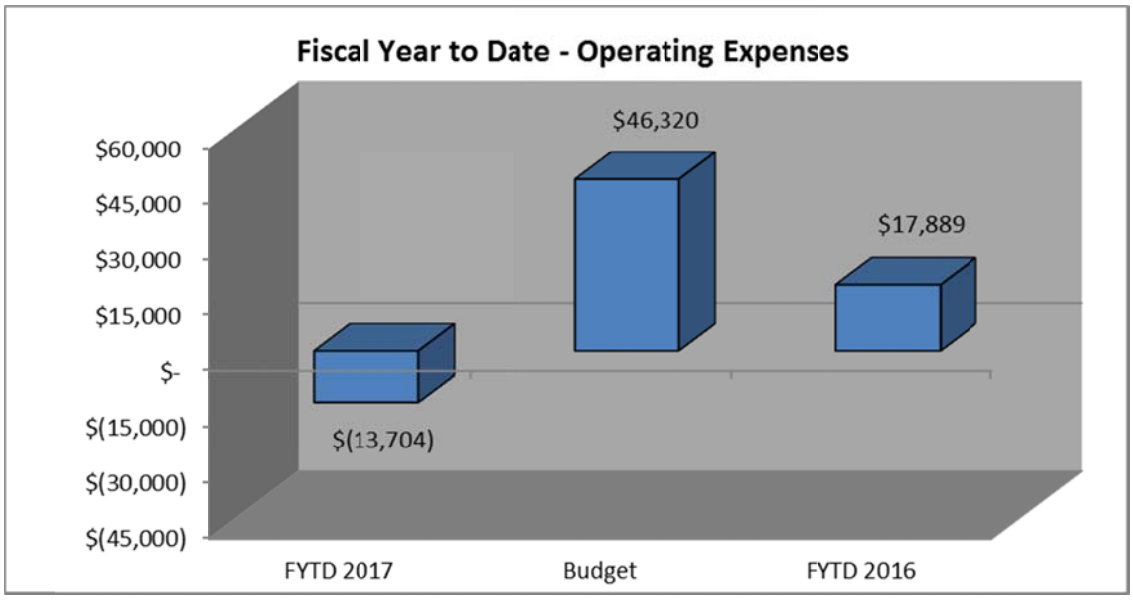
2. Expenses



Total operating expenses have increased by 7.9% for the nine months ended September 30, 2017 compared to the same time period in 2017. Affiliation transactions with five new organizations occurred during the year, contributing $129.5 million of incremental expense year over year. Excluding these, operating expenses increased 3.6% compared to 2016. Actual operating expenses were unfavorable to budget by 4.0% for the nine months ended September 30, and were favorable to budget by 0.2% when excluding the new and unbudgeted affiliations. Excluding the favorability in expenses compared to budget caused by the divestiture of PPIC at the end of the second quarter, operating revenues, less the incremental amount from unbudgeted affiliations, were unfavorable to budget by $57.7 million, or 1.9%. This increase is largely driven by a one-time pension termination cost of $41.6 million and the slightly higher than budgeted revenue.

Despite the one-time item mentioned above, expense growth continues to outpace revenue growth, which has been driven by the same factors that have been experienced over the last year. A shortage of healthcare workers in some of the markets in which the System operates has caused the need to supplement staffing through temporary and contracted resources at rates higher than normal. This includes the usage of locum providers to supplement employed physicians and mid-level providers.

3. Operating Margin



Prior to the reduction for noncontrolling interest, the system had an operating loss of $9.7 million, reflecting an operating margin of negative 0.3%. Management considers Income (Loss) Attributable to UnityPoint Health to be a better performance metric than operating income due to the former representing only the portion of income or loss belonging to UnityPoint Health under consolidated ownership principals. The loss Attributable to UnityPoint Health was $13.7 million, representing an operating margin of negative 0.4%, for the nine months ended September 30, 2017 compared to prior year of 0.6% and budget of 1.5%.

One significant one-time item was recognized during the third quarter that management excludes when assessing performance. This item is $41.6 million of costs related to the termination of a defined benefit plan, which negatively impacted operating income. Excluding this item, Income Attributable to UnityPoint Health would have been $27.9 million, representing a 0.9% operating margin.

Significant efforts are underway to improve performance over the duration of 2017 and sustainably into 2018 and beyond. These efforts are focused on revenue cycle improvements, optimization of labor expense, and sustainable reductions in supply costs. Management has placed heavy emphasis on core operating performance and profitability to achieve budgeted margins going forward. While the majority of the benefit from these initiatives will not lead to significant improvement until 2018, management expects to begin realizing gains during the fourth quarter.

On September 1, 2017, Moody's Investors Service ("Moody's") lowered its long-term and underlying rating to A1 (stable) from Aa3 (negative outlook). Concurrent with this action, Moody's affirmed the P-1 assigned to the System's self-liquidity backed commercial paper program. This downgrade does not limit the System's ability to access the financial markets and with the System's current Fitch rating of AA-, the combined A1/AA- still makes the System one of the more highly rated health systems in the country. The new report by Moody's highlights some of the System's strengths, such as broad diversity of revenue and cash flows across multiple markets and states, manageable debt, capital spending, and a strong balance sheet. Challenges include softer operating performance, risk associated with the Madison JOA and the building of a health plan. The rationale provided by Moody's for the downgrade is "material deviation from budget in fiscal 2016 after demonstrating softer than historic performance in fiscal 2015." The report also states "continuation of modest cash flow in fiscal 2017" and the expectation that it will take several years to restore margins to prior levels. The System is taking the appropriate steps to turnaround operating performance by continuing to engage in a strategy that management believes will result in the best outcome for every patient every time while creating long-term strength and profitable performance.

4. Nonoperating Activity and Other Changes in Net Assets

Nonoperating revenue was a positive $154.1 million for the six months ended June 30, 2017, compared to $36.2 million earned during the same period in 2016. The main drivers of this increase were strong returns in the capital markets during 2017, which generated gains on the System's investment portfolio, $40.5 million of contribution revenue resulting from the unrestricted net asset value of the newly affiliated entities during 2017, and $22.7 million of losses incurred on bond refinancing transactions during 2016 that did not occur in 2017.

5. Key Ratios and Operational Statistics

KEY FINANCIAL RATIOS

	9/30/2017	12/31/2016
Days cash on hand (debt covenant)	208.21	211.49
Debt to capitalization	27.74%	29.12%
Cash to debt	191.42%	192.60%
Net days in accounts receivable	59.27	47.51

KEY OPERATING STATISTICS - HOSPITAL ONLY

	9/30/2017	9/30/2016
Discharges (excluding newborns)	99,817	96,331
Adjusted Patient Days (excluding newborns)	1,015,089	945,261
Adjusted Discharges (excluding newborns)	224,762	207,781
Average Length of Stay (excluding newborns)	4.68	4.80

Days cash on hand (calculated per debt covenant definitions under the System's master trust indenture) has decreased by 3.28 days from December 31, 2016 to September 30, 2017. This is driven primarily by the increase in net days in accounts receivable due to the addition of newly affiliated entities during the year that have longer aged receivables in addition to an increase in Medicaid driven by slower payment from the Managed Care Organizations in Iowa.

Inpatient discharges, excluding newborns, increased by 3.36% for the nine months ended September 30, 2017 compared to the same time period in 2016. Adjusted discharges increased by 8.2% over the same comparable period. Excluding the volume impact from new affiliate entities, discharges declined 0.1% and adjusted discharges increased 1.7%.

During the year, the System has seen a shift in the mix of the patient population, with a higher proportion of Medicare patients and fewer patients with commercial insurance plans. This has been experienced in multiple hospital locations and management is currently examining cost structure to manage to a changing mix in reimbursement.