NEW-ISSUE—BOOK-ENTRY ONLY

Ratings: Standard & Poor's: AA-
Moody's: Aa3
Fitch: AA-
(See "RATINGS" herein)

$250,000,000
ALLINA HEALTH SYSTEM
Taxable Bonds
Series 2015

$250,000,000 4.805% Bonds due November 15, 2045

Price: 100% Yield: 4.805% CUSIP* 01959LAA0

Dated: Date of Issuance **Interest Payable:** May 15 and November 15

The Allina Health System Taxable Bonds, Series 2015 (the "Bonds") will be issued by Allina Health System ("Allina Health") under the Bond Indenture, as described herein. Principal of and redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds will be payable from payments made by Allina Health under the Bond Indenture and from certain funds held under the Bond Indenture. The obligations of Allina Health to make payments under the Bond Indenture will be evidenced by the Series 2015 Obligation issued under the Master Trust Indenture, dated as of October 1, 1998 (as supplemented and amended, the "Master Indenture"), between Allina Health and Wells Fargo Bank, National Association, as successor master trustee.

The Bonds will be issued in book-entry only form through The Depository Trust Company ("DTC"), which will act as securities depository. Purchases of beneficial interests in the Bonds will be made in book-entry form through DTC participants in denominations of $1,000 or any integral multiple thereof. Payments of principal of redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds will be made to beneficial owners by DTC through its participants. See "THE BONDS – Book-Entry Only System" herein.

The Bonds will mature on the date and bear interest payable at the rate per annum shown above on this cover page of this Offering Memorandum. Interest on the Bonds will be payable on May 15 and November 15 of each year, commencing November 15, 2015.

The Bonds are redeemable prior to maturity as described herein.

Interest on, and gain, if any, on the sale of the Bonds are not excludable from gross income for federal, state or local income tax purposes. See "CERTAIN UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS" herein.

This cover page contains certain information for general reference only. It is not intended to be a summary of the security or terms of the Bonds. Investors are advised to read the entire Offering Memorandum, including the Appendices attached hereto, to obtain information essential to the making of an informed investment decision.

The Bonds are offered when, as and if issued and received by the Underwriters and subject to the approving opinion of Dorsey & Whitney LLP, Minneapolis, Minnesota, counsel to Allina Health, and certain other conditions. Certain legal matters will be passed upon for the Underwriters by their counsel, Orrick, Herrington & Sutcliffe LLP. It is expected that the Bonds in definitive form will be available for delivery through the facilities of DTC in New York, New York on or about September 16, 2015.

J.P. Morgan

Piper Jaffray **US Bancorp** **Wells Fargo Securities**

Dated: September 9, 2015

No broker, dealer, salesperson or other person has been authorized by Allina Health or J.P. Morgan Securities LLC, Piper Jaffray & Co., U.S. Bancorp Investments, Inc. or Wells Fargo Securities, LLC (collectively, the "Underwriters") to give any information or to make any representations other than those contained in this Offering Memorandum in connection with the offering made hereby and, if given or made, such information or representations must not be relied upon as having been authorized by Allina Health or the Underwriters. Neither the delivery of this Offering Memorandum nor any sale hereunder shall under any circumstances create any implication that there has been no change in the affairs of Allina Health since the date hereof. This Offering Memorandum does not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of the Bonds in any jurisdiction to any person to whom it is unlawful to make such offer, solicitation or sale.

The information set forth herein has been obtained from Allina Health and other sources that are believed to be reliable. The adequacy, accuracy or completeness of such information is not guaranteed by, and is not to be construed as a representation of, the Underwriters. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Offering Memorandum, nor any sale made hereunder, shall under any circumstances create any implication that there has been no change in the affairs of Allina Health or The Depository Trust Company since the date hereof.

References to website addresses presented herein are for informational purposes only and may be in the form of a hyperlink solely for the reader's convenience. Unless specified otherwise, such websites and the information or links contained therein are not incorporated into, and are not part of, this Offering Memorandum.

THE UNDERWRITERS HAVE PROVIDED THE FOLLOWING SENTENCE FOR INCLUSION IN THIS OFFERING MEMORANDUM: THE UNDERWRITERS HAVE REVIEWED THE INFORMATION IN THIS OFFERING MEMORANDUM IN ACCORDANCE WITH, AND AS PART OF, THEIR RESPONSIBILITIES TO INVESTORS UNDER THE FEDERAL SECURITIES LAWS AS APPLIED TO THE FACTS AND CIRCUMSTANCES OF THIS TRANSACTION, BUT THE UNDERWRITERS DO NOT GUARANTEE THE ACCURACY OR COMPLETENESS OF SUCH INFORMATION.

THE BONDS AND THE SERIES 2015 OBLIGATION HAVE NOT BEEN REGISTERED WITH THE SECURITIES AND EXCHANGE COMMISSION UNDER THE SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), AND ARE BEING ISSUED IN RELIANCE ON AN EXEMPTION UNDER SECTION 3(A)(4) OF THE SECURITIES ACT. NEITHER THE BOND INDENTURE NOR THE MASTER INDENTURE HAVE BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACT. THE BONDS ARE NOT EXEMPT IN EVERY JURISDICTION IN THE UNITED STATES; SOME JURISDICTIONS' SECURITIES LAWS (THE "BLUE SKY LAWS") MAY REQUIRE A FILING AND A FEE TO SECURE THE BONDS' EXEMPTION FROM REGISTRATION.

IN CONNECTION WITH THE OFFERING OF THE BONDS, THE UNDERWRITER MAY OVERALLOT OR EFFECT TRANSACTIONS WHICH STABILIZE OR MAINTAIN THE MARKET PRICE OF THE BONDS OFFERED HEREBY AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

IN MAKING AN INVESTMENT DECISION INVESTORS MUST RELY ON THEIR OWN EXAMINATION OF THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THE BONDS HAVE NOT BEEN APPROVED OR DISAPPROVED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THE OFFERING MEMORANDUM. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS IN THIS OFFERING MEMORANDUM

Certain statements included in this Offering Memorandum constitute "forward-looking statements." Such statements generally are identifiable by the terminology used such as "plan," "expect," "estimate," "budget" or other similar words. Such forward-looking statements include but are not limited to certain statements contained in the information under the caption "BONDHOLDERS' RISKS" in the forepart of this Offering Memorandum and in APPENDIX A – "ALLINA HEALTH SYSTEM." These statements reflect the current views of Allina Health with respect to future events and the achievement of certain results or other expectations contained in such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Other than as may be required by applicable law, Allina Health does not plan to issue or cause to be issued any updates or revisions to those forward-looking statements if or when its expectations or events, conditions or circumstances on which such statements are based occur.

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SUMMARY OF THE OFFERING

Issuer	Allina Health System ("Allina Health").
Securities Offered	$250,000,000 4.805% Allina Health System Taxable Bonds, Series 2015, due November 15, 2045.
Interest Accrual Dates	Interest will accrue from the Date of Issuance.
Interest Payment Dates	May 15 and November 15 of each year, commencing November 15, 2015.
Redemption	The Bonds are redeemable prior to maturity, at the written direction of Allina Health to the Bond Trustee, as a whole or in part on any Business Day, (i) prior to May 15, 2045 at the Make-Whole Redemption Price, as further described herein, together with accrued interest thereon to the redemption date, and (ii) on or after May 15, 2045 at a redemption price equal to 100% of the aggregate principal amount of such Bonds to be redeemed, together with accrued interest thereon to the redemption date. See "THE BONDS – Redemption – Optional Redemption" herein. The Bonds are also subject to Mandatory Sinking Account redemption as further described herein. See "THE BONDS – Redemption – Mandatory Sinking Account Redemption" herein.
Date of Issuance	September 16, 2015.
Authorized Denominations	$1,000 and any integral multiple thereof.
Form and Depository	The Bonds will be delivered solely in book-entry form through the facilities of DTC.
Use of Proceeds	Allina Health will use proceeds of the Bonds for eligible corporate purposes and to pay costs of issuance relating to the Bonds. See "PLAN OF FINANCE" herein.
Ratings	Standard & Poor's: "AA-" Moody's: "Aa3" Fitch: "AA-" For an explanation of the ratings, see "RATINGS" herein.

OFFERING MEMORANDUM

relating to

$250,000,000
Allina Health System
Taxable Bonds
Series 2015

INTRODUCTORY STATEMENT

The following introductory statement is subject in all respects to the more complete information set forth in this Offering Memorandum, including the cover page and appendices hereto (the "Offering Memorandum"). All descriptions and summaries of documents referred to herein do not purport to be comprehensive or definitive and are qualified in their entirety by reference to each such document. Reference is made to each such document for the complete details of all terms and provisions thereof. All capitalized terms used in this Offering Memorandum and not otherwise defined herein have the same meaning as in the Series 2015 Obligation, the Master Indenture or the Bond Indenture, as applicable (each defined herein). See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – DEFINITIONS OF CERTAIN TERMS UNDER THE MASTER INDENTURE AND SECURITY AGREEMENT" and "– SUMMARY OF THE BOND INDENTURE – Certain Definitions Under the Bond Indenture."

General

The purpose of this Offering Memorandum, including the cover page and appendices hereto, is to furnish certain information in connection with the issuance and offering by Allina Health System ("Allina Health") of the Allina Health System Taxable Bonds, Series 2015 (the "Bonds"). The Bonds will be issued by Allina Health under a Bond Indenture, dated as of September 1, 2015 (the "Bond Indenture"), between Allina Health and Wells Fargo Bank, National Association, as bond trustee (the "Bond Trustee"). Principal of and redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds will be payable from payments made by Allina Health under the Bond Indenture and from certain funds held under the Bond Indenture. The obligations of Allina Health to make payments under the Bond Indenture will be evidenced by the Allina Health System Direct Note Obligation, Series 2015 (the "Series 2015 Obligation") issued concurrently with the Bonds under the Master Trust Indenture, dated as of October 1, 1998 (as supplemented and amended, the "Master Indenture"), between Allina Health and Wells Fargo Bank, National Association, as successor master trustee (the "Master Trustee") and the Twentieth Supplemental Master Indenture (the "Supplemental Master Indenture"), dated as of September 1, 2015, between Allina Health and the Master Trustee. See "THE BONDS" and "SECURITY FOR THE BONDS."

Purpose of the Bonds

Allina Health will use proceeds of the Bonds for eligible corporate purposes and to pay costs of issuance relating to the Bonds. See "PLAN OF FINANCE."

Allina Health System

Allina Health is a Minnesota nonprofit corporation exempt from federal income taxation as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). Allina Health is the sole obligated party under the Bond Indenture and, as of the date of issuance of the Bonds, will be the only Member (defined below) of the Obligated Group (defined below). Allina Health, together with its subsidiaries, delivers health care services to patients in Minnesota and Western Wisconsin. For more information about Allina Health and its subsidiaries, see APPENDIX A – "ALLINA HEALTH SYSTEM" and APPENDIX B – "CONSOLIDATED FINANCIAL STATEMENTS FOR ALLINA HEALTH SYSTEM FOR THE FISCAL YEARS ENDED DECEMBER 31, 2014, 2013, AND 2012."

The Obligated Group, the Credit Group and the Master Indenture

As of the date of issuance of the Bonds, Allina Health will be the only Member of the Obligated Group (the "Obligated Group") established under the Master Indenture. Allina Health, as the sole Member of the Obligated Group, is obligated to pay when due the principal of, premium, if any, and interest on each Obligation issued under the Master Indenture, including the Series 2015 Obligation. Other entities may become members of the Obligated Group (each, a "Member," Obligated Group Member" or "Member of the Obligated Group") and Members of the Obligated Group may withdraw from the Obligated Group in accordance with the procedures set forth in the Master Indenture. The Master Indenture imposes no financial tests for new Obligated Group Members to be added or, once added, for Obligated Group Members to withdraw from the Obligated Group. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE – Entrance into the Obligated Group" and "– Cessation of Status as an Obligated Group Member." Allina Health has no present intention to add any Members to the Obligated Group.

The Master Indenture creates a "Credit Group" which consists of (1) Obligated Group Members, (2) Designated Affiliates, (3) Limited Designated Affiliates, (4) Limited Credit Group Participants and (5) Unlimited Credit Group Participants. Each member of the Credit Group is referred to herein as a "Credit Group Member" or "Member of the Credit Group." Each Member of the Obligated Group is jointly and severally obligated to make payments on all Obligations issued under the Master Indenture, including the Series 2015 Obligation. Any Designated Affiliates, Limited Designated Affiliates, Limited Credit Group Participants or Unlimited Credit Group Participants will not be obligated to make any payments on any Obligations; however, they may be required to transfer funds to the Obligated Group Members in amounts necessary to make payments due on Obligations (as further set forth in the Master Indenture). Certain of the covenants and requirements of the Master Indenture are based on financial information of both the Obligated Group Members and such other Credit Group Members, if any, even though only Obligated Group Members directly secure the Obligations issued under the Master Indenture. See "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement." See also APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE." There are currently no Credit Group Members other than Allina Health and Allina Health has no present intention to add any Credit Group Members.

Allina Health has previously authorized the issuance of Obligations under the Master Indenture that are currently Outstanding and that will remain Outstanding upon issuance of the Bonds and the Series 2015 Obligation. See "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement – No Limitations on Incurrence of Additional Indebtedness" and "– Outstanding Obligations."

Security Agreement

As security for its obligations under the Master Indenture, Allina Health has granted to the Master Trustee a security interest in Pledged Revenues pursuant to a Security Agreement, dated as of October 1, 1998, between Allina Health and the Master Trustee, as amended by the First Amendment to Security Agreement, dated as of October 1, 2007, the Second Amendment to Security Agreement, dated as of June 1, 2008, the Third Amendment to Security Agreement, dated as of November 1, 2009, the Fourth Amendment to Security Agreement, dated as of December 1, 2014 and the Fifth Amendment to Security Agreement dated as of September 1, 2015 (collectively, the "Security Agreement"). See "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement."

Bondholders' Risks

There are certain risks involved in the purchase of the Bonds. See "BONDHOLDERS' RISKS."

Continuing Disclosure

Allina Health, as Obligated Group Agent, will enter into a continuing disclosure undertaking, for the benefit of the Holders of the Bonds, where Allina Health will agree to provide certain information annually and quarterly, and to provide notice of certain events. See "CONTINUING DISCLOSURE" and APPENDIX D – "FORM OF CONTINUING DISCLOSURE UNDERTAKING."

THE BONDS

The following is a summary of certain provisions of the Bonds. Reference is made to the Bonds for the complete text thereof and to the Bond Indenture for all of the provisions relating to the Bonds. The discussion herein is qualified by such reference. See also APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE BOND INDENTURE."

General

The Bonds are being issued pursuant to the Bond Indenture in the aggregate principal amount and with the maturity date set forth on the cover of this Offering Memorandum. The Bonds will be delivered in fully registered form without coupons. The Bonds will be dated the Date of Issuance and will be payable as to principal, subject to the redemption provisions set forth herein, on the date and in the amount set forth on the cover page hereof. The Bonds will be transferable and exchangeable as set forth in the Bond Indenture and, when issued, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Bonds. Ownership interests in the Bonds may be purchased in book-entry form only, in denominations of $1,000 or any integral multiple thereof. See also "Book-Entry Only System" below.

The Bonds will bear interest at the rate set forth on the cover page hereof payable on May 15 and November 15 of each year, commencing November 15, 2015 (each an "Interest Payment Date"). Interest shall be payable on each Interest Payment Date for the period commencing on the immediately preceding Interest Payment Date and ending on the day immediately preceding such Interest Payment Date. Interest will be calculated based on a 360-day year consisting of twelve 30-day months. Interest on the Bonds shall be payable on each Interest Payment Date by the Bond Trustee by check mailed on the date on which due to the Holders of Bonds at the close of business on the Record Date (which will be, with respect to any Interest Payment Date, the first day (whether or not a Business Day) of the calendar month in which such Interest Payment Date falls) in respect of such Interest Payment Date at the registered addresses of Holders as shall appear on the registration books of the Bond Trustee. In the case of any Holder of Bonds in an aggregate principal amount in excess of $1,000,000 as shown on the registration books of the Bond Trustee who, prior to the Record Date next preceding any Interest Payment Date, shall have provided the Bond Trustee with written wire transfer instructions, interest payable on such Bonds shall be paid in accordance with the wire transfer instructions provided by the Holder of such Bonds.

If available funds are insufficient on any Interest Payment Date to pay the interest then due on the Bonds, interest shall continue to accrue thereon but shall cease to be payable to the Holders as of the related Record Date. If sufficient funds for the payment of such overdue interest thereafter become available, the Bond Trustee shall (A) establish a "special interest payment date" for the payment of the overdue interest and a Special Record Date (which shall be a Business Day) for determining the Bondholders entitled to such payment and (B) mail notices by first class mail of such dates as soon as practicable. Notice of each such date so established shall be mailed to each Bondholder at least ten (10) days prior to the Special Record Date but not more than thirty (30) days prior to the Special Interest Payment Date. The overdue interest shall be paid on the special interest payment date to the Holders, as shown on the registration books of the Bond Trustee as of the close of business on the Special Record Date.

Payment of the principal, redemption price, including Make-Whole Redemption Price, if any, of the Bonds will be payable in lawful money of the United States of America upon presentation and surrender thereof at the designated corporate trust office of the Bond Trustee.

So long as Cede & Co. is the registered owner of the Bonds, principal of and redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds are payable by wire transfer by the Bond Trustee to Cede & Co., as nominee for DTC, which, in turn, will remit such amounts to DTC Participants (as defined herein) for subsequent disbursement to the Beneficial Owners. See "Book-Entry Only System" below.

Allina Health cannot and does not give any assurances that DTC will distribute to DTC Participants or that DTC Participants or others will distribute to the Beneficial Owners payments of principal of, redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds or any redemption or other notices or that they will do so on a timely basis or will serve and act in the manner described in this Offering Memorandum.

Allina Health is neither responsible nor liable for the failure of DTC or any DTC Participant or DTC Indirect Participant to make any payments or give any notice to a Beneficial Owner with respect to the Bonds or any error or delay relating thereto.

Redemption

Optional Redemption. The Bonds are redeemable prior to maturity, at the written direction of Allina Health to the Bond Trustee, as a whole or in part on any Business Day, (i) prior to May 15, 2045 at the Make-Whole Redemption Price, together with accrued interest thereon to the redemption date, and (ii) on or after May 15, 2045 at a redemption price equal to 100% of the aggregate principal amount of such Bonds to be redeemed, together with accrued interest thereon to the redemption date. As used herein, the Make-Whole Redemption Price shall mean the greater of (i) 100% of the principal amount of any Bonds being redeemed, or (ii) the sum of the present values of the remaining scheduled payments of principal and interest on any Bonds being redeemed (exclusive of interest accrued to the date of redemption) discounted to the redemption date on a semi-annual basis (assuming a 360-day year consisting of twelve 30-day months) at the Treasury Rate plus 30 basis points. The Make-Whole Redemption Price shall be determined by an independent accounting firm or financial advisor retained by Allina Health and such accounting firm or financial advisor shall perform all actions and make all calculations required to determine the Make-Whole Redemption Price. The Bond Trustee and Allina Health may conclusively rely on such accounting firm's or financial advisor's calculations in connection with, and determination of, the Make-Whole Redemption Price, and shall bear no liability for such reliance. For purposes of this paragraph, the following definitions shall apply:

"Comparable Treasury Issue" shall mean, the United States Treasury security or securities selected by a Designated Investment Banker as having an actual or interpolated maturity comparable to the remaining average life of the Bonds to be redeemed that would be utilized, at the time of selection and in accordance with customary financial practice, in pricing new issues of corporate debt securities of a comparable maturity to the remaining term of such Bonds.

"Comparable Treasury Price" shall mean, with respect to any redemption date, the average of the Reference Treasury Dealer Quotations for such redemption date, excluding the highest and lowest of such Reference Treasury Dealer Quotations, or, if the Designated Investment Banker obtains only one Reference Treasury Dealer Quotation, such Reference Treasury Dealer Quotation.

"Designated Investment Banker" shall mean one of the Reference Treasury Dealers appointed by Allina Health.

"Reference Treasury Dealer" shall mean J.P. Morgan Securities LLC, one primary U.S. government securities dealer (a "Primary Treasury Dealer") selected by Wells Fargo Securities, LLC, one Primary Treasury Dealer selected by U.S. Bancorp Investments, Inc., and Piper Jaffray & Co., or their respective affiliates, which are Primary Treasury Dealers, and their respective successors; provided that if J.P. Morgan Securities LLC, the Primary Treasury Dealer selected by Wells Fargo Securities, LLC, the Primary Treasury Dealer selected by U.S. Bancorp Investments, Inc., or Piper Jaffray & Co., or their respective affiliates, shall cease to be a Primary Treasury Dealer, Allina Health shall substitute therefor another Primary Treasury Dealer.

"Reference Treasury Dealer Quotations" shall mean, with respect to each Reference Treasury Dealer and any redemption date for the Bonds, the average, as determined by the Designated Investment Banker, of the bid and asked prices for the Comparable Treasury Issue (expressed in each case as a percentage of its principal amount) quoted in writing to the Designated Investment Banker by such Reference Treasury Dealer at 3:30 p.m., New York City time, on the third Business Day preceding such redemption date.

"Treasury Rate" shall mean, with respect to any redemption date, for the Bonds, the rate per annum equal to the semiannual equivalent yield to maturity or interpolated (on a day count basis) of the Comparable Treasury Issue, computed as of the second Business Day immediately preceding such redemption date, assuming a price for the Comparable Treasury Issue (expressed as a percentage of its principal amount) equal to the Comparable Treasury Price for such redemption date.

Mandatory Sinking Account Redemption. The Bonds are also subject to redemption prior to their stated maturity in part from Mandatory Sinking Account Payments on any November 15 on or after November 15, 2041, at the principal amount thereof together with interest accrued thereon to the date fixed for redemption, without premium, in the amounts and on the dates set forth below:

Mandatory Sinking Account Payment Dates (November 15)	Mandatory Sinking Account Payments
2041	$50,000,000
2042	$50,000,000
2043	$50,000,000
2044	$50,000,000
2045‡	$50,000,000

‡ Final Maturity

Notice of Redemption of the Bonds. Notice of redemption shall be mailed by the Bond Trustee, not less than 20 days or more than 60 days prior to the redemption date, to the Holders of Bonds called for redemption at their addresses appearing on the bond registration books of the Bond Trustee and to the Master Trustee, with a copy to the Obligated Group Agent and Allina Health. For any redemption in whole, the Bond Trustee shall also provide notice of such redemption to each Rating Agency then rating the Bonds. Each notice of redemption shall state the date of such notice and date of issue of the Bonds, the redemption date, the Make-Whole Redemption Price or the aggregate principal amount of the Bonds to be redeemed, as applicable, the place or places of redemption (including the name and appropriate address or addresses of the Bond Trustee), the maturity, the CUSIP number, if any, and any conditions to the redemption, and, in the case of Bonds to be redeemed in part only, the respective portions of the principal amount thereof to be redeemed. Each such notice shall also state that, subject to prior rescission, on said date there will become due and payable on each of said Bonds the Make-Whole Redemption Price or the aggregate principal amount of such Bonds, as applicable, or of said specified portion of the principal amount thereof in the case of a Bond to be redeemed in part only, together with interest accrued thereon to the redemption date, and that from and after such redemption date interest thereon shall cease to accrue, and shall require that the Bonds be then surrendered. Each notice shall also state that redemption is conditioned upon receipt by the Bond Trustee of sufficient funds on the redemption date to pay the Make-Whole Redemption Price or the aggregate principal amount, as applicable, of the Bonds to be redeemed and on such other conditions as may be specified by the Obligated Group Agent.

Any notice of optional redemption may be rescinded by written notice given to the Bond Trustee by the Obligated Group Agent no later than 5 Business Days prior to the date specified for redemption. The Bond Trustee shall give notice of such rescission as soon thereafter as practicable in the same manner, and to the same Persons, as notice of such redemption was given pursuant to the Bond Indenture.

Failure by the Bond Trustee to mail notice of redemption to any one or more of the respective Holders of any Bonds designated for redemption shall not affect the sufficiency of the proceedings for redemption with respect to the Holders to whom such notice was mailed.

Effect of Redemption. Notice of redemption having been duly given pursuant to the Bond Indenture, and moneys for payment of the Make-Whole Redemption Price or the aggregate principal amount of the Bonds to be redeemed, as applicable of, together with interest accrued to the redemption date on, the Bonds (or portions thereof) so called for redemption being held by the Bond Trustee, on the redemption date designated in such notice, the Bonds (or portions thereof) so called for redemption shall become due and payable at the Make-Whole Redemption Price or the aggregate principal amount of the Bonds, as applicable, specified in such notice together with interest accrued thereon to the redemption date, interest on the Bonds so called for redemption shall cease to accrue, said Bonds (or portions thereof) shall cease to be entitled to any benefit or security under the Bond Indenture and the Holders of said Bonds shall have no rights in respect thereof except to receive payment of said Make-Whole Redemption Price or the aggregate principal amount of such Bonds, as applicable, and accrued interest to the date fixed for redemption from funds held by the Bond Trustee for such payment.

Selection of Bonds for Redemption. Whenever provision is made in the Bond Indenture for the redemption of less than all of the Bonds or any given portion thereof, the Bond Trustee shall select the Bonds to be redeemed, from all Bonds subject to redemption or such given portion thereof not previously called for redemption, on a pro rata pass-through distribution of principal basis.

If the Bonds are registered in book-entry only form and so long as Cede & Co. (DTC's partnership nominee) or its registered assigns or a successor securities depository is the sole registered owner of such Bonds, if less than all of the Bonds are called for prior redemption, the particular Bonds or portions thereof to be redeemed shall be allocated on a pro rata pass-through distribution of principal basis in accordance with Cede & Co. or its registered assigns or a successor securities depository procedures, provided that, so long as the Bonds are held in book-entry form, the selection for redemption of such Bonds shall be made in accordance with the operational arrangements of Cede & Co. or its registered assigns or a successor securities depository then in effect, and, if Cede & Co. or its registered assigns or a successor securities depository's operational arrangements do not allow for redemption on a pro rata pass-through distribution of principal basis, the Bonds will be selected for redemption, in accordance with Cede & Co. or its registered assigns or a successor securities depository procedures, by lot.

Allina Health intends that redemption allocations made by Cede & Co. or its registered assigns or a successor securities depository be made on a pro rata pass-through distribution of principal basis as described above. However, neither Allina Health nor the Underwriters can provide any assurance that Cede & Co. or its registered assigns or a successor securities depository, Cede & Co. or its registered assigns or a successor securities depository's direct and indirect participants or any other intermediary will allocate the redemption of Bonds on such basis.

In connection with any repayment of principal, including payments of scheduled Mandatory Sinking Account Payments, the Bond Trustee will direct Cede & Co. or its registered assigns or a successor securities depository to make a pass-through distribution of principal to the holders of the Bonds. A Pro Rata Pass-Through Distribution of Principal table is included as Appendix E to this Offering Memorandum and reflects the current schedule of Mandatory Sinking Account Payments applicable to the Bonds and the factors applicable to such redemption amounts and remaining bond balances, which is subject to change upon certain optional redemptions. See "APPENDIX E – Pro Rata Pass-Through Distribution of Principal."

For purposes of calculation of the "pro rata pass-through distribution of principal," "pro rata" means, for any amount of principal to be paid, the application of a fraction to each denomination of the respective Bonds where (a) the numerator of which is equal to the amount due to the respective Bondholders on a payment date, and (b) the denominator of which is equal to the total original par amount of the respective Bonds.

If the Bonds are no longer registered in book-entry-only form, each Beneficial Owner will receive an amount of Bonds equal to the original face amount then beneficially held by that Beneficial Owner, registered in such Beneficial Owner's name. Thereafter, any redemption of less than all of the Bonds will continue to be paid to the registered Beneficial Owners of such Bonds on a pro-rata basis, based on the portion of the original face amount of any such Bonds to be redeemed.

Purchase in Lieu of Redemption

Each Holder or Beneficial Owner of the Bonds, by purchase and acceptance of any Bond, irrevocably grants to Allina Health the option to purchase such Bond at any time such Bond is subject to optional redemption as described in the Bond Indenture. Such Bond is to be purchased at a purchase price equal to then applicable redemption price of such Bond. Allina Health shall direct the Bond Trustee to provide notice of mandatory purchase, such notice to be provided, as and to the extent applicable, in accordance with the Bond Indenture and to select Bonds subject to mandatory purchase in the same manner as Bonds called for redemption pursuant to the Bond Indenture. On the date fixed for purchase of any Bond in lieu of redemption, Allina Health shall pay the purchase price of such Bond to the Bond Trustee in immediately available funds, and the Bond Trustee shall pay the same to the Holders of the Bonds being purchased against delivery thereof. No purchase of any Bond in lieu of redemption shall operate to extinguish the indebtedness of Allina Health evidenced by such Bond. No Holder or Beneficial Owner may elect to retain a Bond subject to mandatory purchase in lieu of redemption. Allina Health may exercise its option to purchase Bonds, in whole or in part.

Additional Bonds

The Bond Indenture provides that, subsequent to the issuance of the Bonds, Allina Health may issue Additional Bonds pursuant to a supplemental indenture, without notice to or the consent of the Bondholders. Any Additional Bonds so issued will have the same form and terms, as the Bonds, including being subject to redemption at the same times and at the same redemption price including Make-Whole Redemption Price, if any, as the Bonds, (other than the date of issuance and, under certain circumstances, the date from which interest thereon will begin to accrue), and will carry the same right to receive accrued and unpaid interest, as the Bonds, previously issued, and such Additional Bonds will form a single series with the Bonds. As a condition to any such issuance of Additional Bonds, Allina Health would need to certify that, among other things, such issuance would not cause any adverse tax impact to the then-existing Holders of outstanding Bonds. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE BOND INDENTURE – Additional Bonds."

Book-Entry Only System

The Depository Trust Company ("DTC"), New York, New York, will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond certificate will be issued for the Bonds, in the aggregate principal amount of the Bonds, and will be deposited with DTC.

DTC is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non-U.S. equity issues, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company of DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others, such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a Standard & Poor's rating of AA+. The DTC rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their beneficial ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual

Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of the Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Bonds, such as redemptions, tenders, defaults, and proposed amendments to the bond documents. For example, Beneficial Owners of the Bonds may wish to ascertain that the nominee holding the Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the Bond Trustee and request that copies of notices be provided directly to them.

Redemption notices shall be sent to DTC. If less than all of the Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to Allina Health as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts such Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Principal, redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from Allina Health or the Bond Trustee, on the payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC nor its nominee, the Bond Trustee or Allina Health, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal, redemption price, including Make-Whole Redemption Price, if any, and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to Allina Health or the Bond Trustee. Under such circumstances, in the event that a successor depository is not obtained, Bond certificates are required to be printed and delivered.

Allina Health may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, Bond certificates are required to be printed and delivered to DTC or Beneficial Owners, as applicable.

The preceding information in this section "Book-Entry Only System" has been provided by DTC. No representation is made by Allina Health, the Underwriters or the Bond Trustee as to the accuracy or adequacy of such information provided by DTC or as to the absence of material adverse changes in such information subsequent to the date of this Offering Memorandum.

PLAN OF FINANCE

Purpose of the Bonds

Allina Health will use proceeds of the Bonds for eligible corporate purposes and to pay costs of issuance relating to the Bonds. See "PLAN OF FINANCE."

ESTIMATED SOURCES AND USES OF FUNDS

The proceeds to be received from the sale of the Bonds are expected to be applied as follows:

Sources of Funds	Total
Par Amount of Bonds	$250,000,000
Total Sources of Funds	$250,000,000
Use of Funds	
Eligible Corporate Purposes[(1)]	$250,000,000
Total Uses of Funds	$250,000,000

(1) Includes certain costs of issuance such as underwriting discount, rating agency, legal accounting, consulting, financial advisory, trustee, printing fees and expenses and other fees and expenses of issuing the Bonds.

SECURITY FOR THE BONDS

The Bond Indenture and the Series 2015 Obligation

The Bonds will be general obligations of Allina Health, payable from payments made by Allina Health under the Bond Indenture and from certain funds held under the Bond Indenture. The Bonds are secured by the Indenture Fund and all amounts held therein pursuant to the Bond Indenture.

To secure its obligation to make payments under the Bond Indenture, and to further secure payment of the principal of, and redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds, Allina Health, concurrently with the issuance of the Bonds, will execute and deliver the Series 2015 Obligation to the Bond Trustee. The Series 2015 Obligation will be issued and secured under and pursuant to the Master Indenture between Allina Health and the Master Trustee, and the Supplemental Master Indenture. Pursuant to the Series 2015 Obligation, Allina Health and any future Members of the Obligated Group agree to make the payments under the Bond Indenture including payments to the Bond Trustee in amounts sufficient to pay, when due, the principal of, and redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds. Each Member of the Obligated Group is jointly and severally obligated to make payments on all Obligations issued under the Master Indenture, including the Series 2015 Obligation. Allina Health is currently the only Member of the Obligated Group established under the Master Indenture and, consequently, will be the only entity liable for payment of Obligations issued under the Master Indenture, including the Series 2015 Obligation, as of the date of issuance of the Bonds. See "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement" below.

Allina Health receives credit on payments due under the Bond Indenture to the extent of payment made by the Members of the Obligated Group under the Series 2015 Obligation. The Members of the Obligated Group receive a credit on payments due on the Series 2015 Obligation to the extent of payments made by Allina Health under the Bond Indenture. The Series 2015 Obligation will be secured by the security interest in Pledged Revenues granted by Allina Health to the Master Trustee pursuant to the Security Agreement as described herein. See "– The Master Indenture – Security Agreement" below.

The legal right and practical ability of the Bond Trustee to enforce its rights and remedies against Allina Health under the Bond Indenture, the Security Agreement, the Master Indenture and the Series 2015 Obligation and related documents could be limited by laws relating to bankruptcy, insolvency, reorganization, fraudulent conveyance or moratorium and by other similar laws affecting creditors' rights. See "SECURITY FOR THE BONDS – Limitations on Enforceability" below and see "BONDHOLDERS' RISKS – Other Risk Factors – Bankruptcy and Insolvency" herein.

The Master Indenture and the Security Agreement

General. Under the Master Indenture, the Members of the Obligated Group, as they may exist from time to time, jointly and severally guarantee the payment of all obligations secured under the Master Indenture (the "Obligations"), including the Series 2015 Obligation and any other Obligations Outstanding from time to time. Accordingly, Allina Health and any future Members of the Obligated Group jointly and severally are required to make payments on the Series 2015 Obligation sufficient to provide for the full payment of principal of, redemption price, including Make-Whole Redemption Price, if any, and interest on the Bonds when due. As security for its obligations under the Master Indenture, Allina Health has granted a security interest in Pledged Revenues to the Master Trustee pursuant to the Security Agreement for the protection and benefit of the Holders of all Obligations, including the Bond Trustee as Holder of the Series 2015 Obligation. Any future Members of the Obligated Group will agree upon entrance into the Obligated Group to pledge its Pledged Revenues to the Master Trustee.

The Master Indenture imposes certain limited covenants upon the Obligated Group Members for the benefit of the holders of Obligations (including the Series 2015 Obligation), including covenants, among others, relating to (i) covenant to maintain a minimum historical debt service coverage ratio, (ii) limits upon the sale, lease or other disposition of Property of the Obligated Group Members, and (iii) limitations on the creation of Liens by an Obligated Group Member and any other Credit Group Member in order to secure their respective Indebtedness. The Master Indenture does not contain any limits upon the incurrence of indebtedness. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE."

Membership in Obligated Group and Withdrawal from Obligated Group. The Master Indenture permits other entities to become Members of the Obligated Group under certain circumstances and permits Members of the Obligated Group to be released from their respective obligations under the Master Indenture under certain circumstances. **Members may be added to the Obligated Group or withdrawn from the Obligated Group, in either case, without satisfying any financial or other conditions as long as no event of default, or an event which, with the passage of time or giving of notice, or both, would constitute an event of default, has occurred and is continuing under the Master Indenture or would result from the addition or withdrawal of the Obligated Group Members.** For a description of the provisions of the Master Indenture providing for entry into or withdrawal from the Obligated Group, see APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE – Entrance into the Obligated Group" and "– Cessation of Status as an Obligated Group Member."

Joint and Several Obligations. Under the Master Indenture, Allina Health may incur, for itself and on behalf of any future Members of the Obligated Group, Indebtedness and other liabilities that may be evidenced and secured by Obligations issued under the Master Indenture. Allina Health and any future Members of the Obligated Group are jointly and severally liable with respect to all payments required to be made under the Master Indenture, any indenture supplemental to, and authorized and executed pursuant to the terms of, the Master Indenture and each Obligation issued under the Master Indenture. The Series 2015 Obligation is being issued by Allina Health under and pursuant to the Master Indenture on parity with all other Obligations that have been previously issued and are outstanding under the Master Indenture and that are to be issued on behalf of Allina Health and any future Members of the Obligated Group thereunder. The Master Indenture provides no limitation on the issuance of additional Obligations under the Master Indenture.

The Credit Group. The Master Indenture creates a "Credit Group" which consists of (1) Obligated Group Members, (2) Designated Affiliates, (3) Limited Designated Affiliates, (4) Limited Credit Group Participants and (5) Unlimited Credit Group Participants. There are currently no Credit Group Members other than Allina Health and Allina Health has no present intention to add any Credit Group Members. The Master Indenture provides that the Obligated Group Agent may identify an organization as a Designated Affiliate, Limited Designated Affiliate, Limited Credit Group Participant or Unlimited Credit Group Participant and that, after the Obligated Group Agent so identifies an organization, the Obligated Group Agent may at any time withdraw such designation, in either case, without satisfying any financial or other conditions as long as no event of default, or an event which, with the passage of time or giving of notice, or both, would constitute an event of default, has occurred and is continuing under the Master Indenture or would result from the Obligated Group Agent's withdrawal of such designation.

Accordingly, there can be no assurance that any future Designated Affiliate, Limited Designated Affiliate, Limited Credit Group Participant or Unlimited Credit Group Participant, if any, will continue to be so designated.

Each Member of the Obligated Group is jointly and severally obligated to make payments on all Obligations issued under the Master Indenture, including the Series 2015 Obligation. Any Designated Affiliates, Limited Designated Affiliates, Limited Credit Group Participants or Unlimited Credit Group Participants will not be obligated to make any payments on any Obligations; however, they may be required to transfer funds to the Obligated Group Members in amounts necessary to make payments due on Obligations (as further set forth in the Master Indenture). See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE – The Obligations; Payment of the Obligations and " – The Credit Group." Certain of the covenants and requirements of the Master Indenture are based on financial information of both the Obligated Group Members and such other Credit Group Members, if any, even though only Obligated Group Members directly secure the Obligations issued under the Master Indenture. The operational and financial restrictions and contractual obligations of the Master Indenture apply directly only to Obligated Group Members. There are currently no Credit Group Members other than Allina Health and Allina Health has no present intention to add any Credit Group Members. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE."

Security Agreement. All Outstanding Obligations from time to time under the Master Indenture, including the Series 2015 Obligation, are secured by a security interest in Pledged Revenues granted by Allina Health to the Master Trustee pursuant to the Security Agreement. By the Security Agreement, Allina Health has granted and each future Obligated Group Members will agree to grant to the Master Trustee a security interest in the Pledged Revenues to secure payment of the Obligations and keep all Pledged Revenues free and clear of all security interest, liens and encumbrances except the security interest granted pursuant to the Security Agreement and Permitted Encumbrances, and to defend the Pledged Revenues against all claims or demand (other than claims or demands based on Permitted Encumbrances) of all persons other than the Master Trustee. In addition, the Security Agreement may be waived, modified, amended, terminated or discharged, and the security interest in Pledged Revenues granted can be released with the consent of the Master Trustee, the Bond Trustee, as the holder of the Series 2015 Obligation and certain other parties. "Pledged Revenues" mean all gross revenues, profits, receipts, benefits, royalties, money and income of any Obligated Group Member arising from services provided by Obligated Group Members or arising in any manner related to the Obligated Group Members' operations, including, without limitation, (i) the Obligated Group Members' rights under agreements with insurance companies, Medicare, Medicaid, governmental units and prepaid health organizations, including rights to Medicare and Medicaid loss recapture under applicable regulations and (ii) gifts, grants, bequests, donations, contributions and pledges to any Obligated Group Member and (iii) business interruption insurance proceeds, and all rights to receive the foregoing, whether now owned or hereafter acquired by any Obligated Group Member and regardless of whether generated in the form of accounts, accounts receivable, general intangibles, contract rights or chattel paper and all proceeds of the foregoing, whether cash or noncash; excluding, however, gifts, grants, bequests, donations, contributions and pledges to any Obligated Group Member, and the income and gains derived therefrom, which are specifically restricted by the donor or grantor to a particular purpose which is inconsistent with their use for payments required under the Master Indenture or on the Obligations. "Pledged Revenues" shall not be deemed to include revenues from leases which relate to the Facilities of the Obligated Group Members which are of a type that are customarily entered into for such Facilities, such as office space for physicians and educational institutions, food service facilities, gift shops, radiology and other hospital-based specialty services and pharmacy and similar departments. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE SECURITY AGREEMENT" for a further summary of certain provisions of the Security Agreement.

Security Interest in Pledged Revenues. Pursuant to the Security Agreement, Allina Health has granted and each of the other future Obligated Group Members will grant a security interest in favor of the Master Trustee in Pledged Revenues under Article 9 of the Uniform Commercial Code as in effect in the State (the "UCC"). The security interest in Pledged Revenues will be perfected to the extent, and only to the extent, that the same may be perfected by filing of financing statements under the UCC; i.e., the security interest will be perfected only in those items and types of Pledged Revenues consisting of "accounts" and "general intangibles" (as defined in the UCC). The UCC does not permit perfection by filing with respect to certain items included in Pledged Revenues, such as

the proceeds of accounts, cash or bank deposits, which generally permits perfection only by possession by the Master Trustee or a depository bank under a control agreement. The Master Indenture does not create a gross revenue fund or account in the possession of the Master Trustee or under its control by means of account control agreements. Creation and enforcement of any right to receive payments under the Medicare and Medicaid programs may be subject to limitations under federal and state laws and regulations. Under certain circumstances, the security interest in Pledged Revenues may be subordinated to the interests of creditors other than the Holders of Obligations. Some instances of subordination of prior interests and claims are (i) statutory liens, (ii) rights arising in favor of the United States of America or any agency thereof, (iii) present or future prohibitions against assignment in any federal statutes or regulations, (iv) constructive trusts, equitable liens or other rights impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction, (v) federal or state bankruptcy or insolvency laws that may affect the enforceability of the Master Indenture or the grant of any security interest, (vi) provisions prohibiting the direct payment of amounts due to health care providers from Medicaid and Medicare programs to persons other than such providers, (vii) the absence of an express provision permitting assignment of receivables due under the contracts between the Obligated Group Members and third-party payers, (viii) certain judicial decisions which cast doubt upon the rights of the Master Trustee, in the event of bankruptcy of an Obligated Group Member to collect and retain accounts receivable from Medicare, Medicaid and other governmental programs, (ix) commingling of proceeds of Pledged Revenues with other moneys of the Obligated Group Members not so pledged under the Master Indenture, (x) federal or state laws governing fraudulent transfers, (xi) rights of third parties in Pledged Revenues converted to cash and not in the possession of the Master Trustee; and (xii) claims that might arise if appropriate financing or continuation statements or amendments to financing statements are not filed in accordance with the Uniform Commercial Code of the applicable state, as from time to time in effect.

Permitted Encumbrances. Pursuant to the Master Indenture, each Member of the Obligated Group agrees that it will not, and that it will not permit any Designated Affiliates or Limited Designated Affiliate under its control or any Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to, to create or incur or permit to be created or incurred or to exist any Lien upon any Property of any Credit Group Member to secure Indebtedness, except for Permitted Encumbrances. The Credit Group may incur substantial liabilities secured by Permitted Encumbrances. See the definition of "Permitted Encumbrances" in APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – DEFINITIONS OF CERTAIN TERMS UNDER THE MASTER INDENTURE AND SECURITY AGREEMENT."

Rate Covenant. The Master Indenture provides that the Obligated Group Agent shall calculate the Historical Debt Service Coverage Ratio of the Credit Group for each Fiscal Year. If for any such Fiscal Year, the Historical Debt Service Coverage Ratio of the Credit Group is less than 1.10 to 1, the Master Trustee shall require the Obligated Group Agent at its expense to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Credit Group and the Credit Group's method of operations and other factors affecting its financial condition in order to increase the Historical Debt Service Coverage Ratio for the succeeding Fiscal Year to at least 1.10 to 1.0.

The Obligated Group covenants in the Master Indenture that it shall maintain a Historical Debt Service Coverage Ratio of the Obligated Group for each Fiscal Year of at least 1.00 to 1. Failure to maintain such Historical Debt Service Coverage Ratio shall not constitute an Event of Default under the Master Indenture for a period of one year, provided that during such year the Obligated Group maintains Days Cash on Hand of at least 75 days. After the expiration of one year or Days Cash on Hand falling below 75 days, the failure to maintain an Historical Debt Service Coverage Ratio of the Obligated Group for each Fiscal Year of at least 1.00 to 1 shall constitute an immediate Event of Default under the Master Indenture, unless as of the end of such Fiscal Year (i) the Obligated Group's Days Cash on Hand was at least 75 days and (ii) the Historical Debt Service Coverage Ratio for the prior Fiscal Year was at least 1.00 to 1. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE – Rates and Charges."

Sale, Lease or Other Disposition of Property. The Master Indenture provides that any Obligated Group Member may not during any Fiscal Year sell, lease, transfer or otherwise dispose (including without limitation any involuntary disposition) of Property to any Person which is not an Obligated Group Member, the Book Value of which Property (determined as of the date of such sale, lease, transfer or disposition) when added to the Book Value

of all other Property transferred by the Obligated Group Members during such Fiscal Year to a Person which is not an Obligated Group Member would exceed 3% of the Revenues of the Obligated Group as of the most recently completed Fiscal Year other than: (a) transfers of Property in the ordinary course of business, or otherwise upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's length transaction; or (b) transfers of Property to any Person if (i) prior to such transfer, the Trustee receives an Officer's Certificate of Allina Health (on behalf of the Obligated Group) in a form acceptable to the Trustee stating that such Property has become or within the next succeeding 12 calendar months is expected to become inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and the disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property, or (ii) the Obligated Group Member transferring such Property acquires and substitutes for the Property transferred other Property of substantially equivalent utility to that so transferred; or (c) transfers of Property if (i) the Historical Debt Service Coverage Ratio of the Obligated Group as of the end of the most recent Fiscal Year exceeded 2.50 to 1, (ii) the Historical Debt Service Coverage Ration of the Obligated Group as of the end of the most recent Fiscal Year calculated after giving effect to such sale, lease, transfer or disposition is at least 1.10 to 1.00 and shall not have declined by more than 25% as compared to the Historical Debt Service Coverage Ratio calculated without giving effect to such transaction, or (iii) the Unrestricted Net Assets of the Obligated Group calculated after giving effect to such sale, lease, transfer or disposition shall not be less than 95% of the Unrestricted Net Assets of the Obligated Group immediately prior to such transaction.

No Limitations on Incurrence of Additional Indebtedness. In addition to the Bonds, Allina Health and each of the other future Members of the Obligated Group, if any, are permitted under the Master Indenture to incur additional Indebtedness, either unsecured or secured by Permitted Encumbrances, without limitation. Additional Indebtedness need not be evidenced by Obligations issued under the Master Indenture. However, only Indebtedness represented by Obligations will be secured by the security interest in the Pledged Revenues on a parity with other Obligations.

Outstanding Obligations.

The following Indebtedness is secured by Outstanding Obligations under the Master Indenture and was outstanding as of June 30, 2015:

City of Minneapolis, Minnesota and Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Variable Rate Health Care System Revenue Bonds (Healthspan) Series 1993B, currently outstanding in the aggregate principal amount of $24,900,000;

City of Minneapolis, Minnesota and Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Variable Rate Demand Revenue Bonds (Allina Health System), Series 1998A, currently outstanding in the aggregate principal amount of $14,575,000;

City of Minneapolis and The Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Health Care System Revenue Bonds, Series 2007A (Allina Health System), currently outstanding in the principal amount of $105,415,000;

City of Minneapolis and The Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Health Care System Variable Rate Demand Revenue Bonds, Series 2007C-1 and Series 2007C-2 (Allina Health System), currently outstanding in the principal amount of $121,250,000;

City of Minneapolis and The Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Health Care System Revenue Bonds, Series 2009A-1 and A-2 (Allina Health System), currently outstanding in the principal amount of $175,275,000;

City of Minneapolis and The Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Health Care System Variable Rate Demand Revenue Bonds, Series 2009B-1 and Series 2009B-2 (Allina Health System), currently outstanding in the aggregate principal amount of $114,525,000;

City of Minneapolis and The Housing and Redevelopment Authority of the City of Saint Paul, Minnesota Health Care System Variable Rate Demand Revenue Bonds, Series 2009C (Allina Health System), currently outstanding in the aggregate principal amount of $50,000,000; and

City of Minneapolis Fixed Rate Health Care Facilities Revenue Note, Series 2014 (Allina Health System), currently outstanding in the principal amount of $20,165,000.

In addition, Allina Health has also issued Obligations under the Master Indenture to secure Allina Health's revolving credit facility, liquidity facilities and reimbursement obligations, certain interest rate swap transactions entered into by Allina Health and obligations to certain insurers to secure amounts owing thereto (collectively, the "Prior Obligations"),

These Obligations are on parity with the Series 2015 Obligation and any future Obligations. See "ANNUAL DEBT SERVICE REQUIREMENTS" herein and APPENDIX A – "ALLINA HEALTH SYSTEM – INVESTMENT MANAGEMENT – Debt and Swap Structure."

Other Master Indenture Covenants. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE" for a summary of certain of the other covenants of the Master Indenture.

Substitution of the Series 2015 Obligation Permitted. Under the circumstances described in the Bond Indenture and the Master Indenture, the Bond Trustee is required to exchange the Series 2015 Obligation for a note or similar obligation (the "Replacement Obligation") of a credit group that could be financially and operationally different from the Credit Group, and the new credit group could have substantial debt outstanding that would rank on a parity with the Replacement Obligation. Such exchange could adversely affect the market price for and marketability of the Bonds. One of the conditions in the Bond Indenture to the substitution is that each rating agency then rating the Bonds must provide written confirmation that the replacement of the Series 2015 Obligation will not, by itself, result in a reduction in the then-current ratings on the Bonds. For a summary of the conditions that must be satisfied before a Replacement Obligation could be exchanged for the Series 2015 Obligation, see – APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE BOND INDENTURE – Replacement of the Series 2015 Obligation with an Obligation Issued Under a Separate Master Indenture" and APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE – Substitution of Obligations under Substitute Master Indenture."

No Debt Service Reserve Fund

No debt service reserve fund will be established or funded in connection with the issuance of the Bonds.

Amendments to Bond Indenture and Master Indenture

Certain amendments may be made to the Bond Indenture without obtaining the consent of any Holders of the Outstanding Bonds and certain other amendments to the Bond Indenture require, subject to the nature of the amendment(s), either the consent of the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding or the consent of all Holders of Bonds. Such amendments that are subject to consent of Holders may adversely affect the security for the Bonds. See APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE BOND INDENTURE – Modification or Amendment of the Bond Indenture; Amendments Permitted." Certain amendments may be made to the Master Indenture without obtaining consent of any Holders of Obligations and certain other amendments to the Master Indenture require, subject to the nature of the amendment(s), one of the following, the consent of the Holders of not less than a majority in aggregate principal amount of the Outstanding Obligations, the consent of the Holder of the Obligation affected by such amendment(s) or the consent of all Holders of Obligations. See APPENDIX C – DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS – SUMMARY OF THE MASTER INDENTURE – Supplemental Master Indentures." With respect to amendments to the Master

Indenture, the Holders of the requisite percentage of Outstanding Obligations may be composed wholly or partially of the Holders of Obligations other than the Series 2015 Obligation.

Certain Additional Covenants for the Benefit of Existing Holders of Other Bonds, Bond Insurers and Financial Institutions Only.

The Obligated Group also has in place agreements with holders and bond insurers, of bonds previously issued for the benefit of Allina Health, and financial institutions which include representations, covenants and agreements in addition to those contained in the Master Indenture. The covenants in such agreements may be waived or modified at the sole discretion of the related holders, bond insurer or financial institution without consent of or notice to any Obligation Holders or Holders of the Bonds and are only applicable while such agreements are in place. An event of default under any such agreements could result in an event of default under the Master Indenture.

Limitations on Enforceability

Risks Related to Master Indenture Financings. There are circumstances under which it is possible that the Master Indenture would not be enforced by courts, especially as to future Members of the Obligated Group. Additionally, there are a number of circumstances under which the security interest in Pledged Revenues pursuant to the Security Agreement, may not be enforced or may be subordinated to the claims of others.

Fraudulent Transfer or Conveyance Statutes. The state of insolvency, fraudulent transfer or conveyance and bankruptcy laws relating to the enforceability of obligations of one corporation in favor of the creditors of another, or the obligation of one Member of the Obligated Group to make debt service payments on behalf of another Member or the ability of a corporate parent to compel its affiliates or subsidiaries to make such payments is unsettled. The ability of the Obligated Group to compel one Member of the Obligated Group to make payment on behalf of another Member could be subject to challenge if such Member would, by making such payment, be rendered insolvent. In particular, such efforts by the Obligated Group may not be enforced under the Federal Bankruptcy Code or applicable state fraudulent transfer or conveyance statutes if the obligation to pay is incurred without "fair consideration" or "reasonably equivalent value" to the obligor-Member and if the incurrence of the obligation renders the Member insolvent. The standards for determining the fairness of consideration and the manner of determining insolvency are not clear and may vary under the Federal Bankruptcy Code, state fraudulent conveyance statutes and other statutes that may be applicable.

In addition a court could determine, in the event of a bankruptcy of a Member, that payments made on the Series 2015 Obligation by a bankrupt Member could constitute payments to or for the benefit of an insider, within the meaning of Section 547(b) of the Bankruptcy Code, which payments, if made within one year of the filing of the bankruptcy petition, might be recoverable by the bankruptcy court from the owners of the Bonds.

If a court were to find that a Member did not receive fair consideration or reasonably equivalent value for the incurrence of the indebtedness evidenced by the Series 2015 Obligation and such Member: (i) was insolvent; (ii) was rendered insolvent by such incurrence; (iii) was engaged in a business activity for which its remaining assets were unreasonably small; or (iv) intended (or believed) to incur, assume or issue, debt beyond its ability to pay, a court could determine to invalidate, the indebtedness represented by the Series 2015 Obligation.

Enforceability of the Series 2015 Obligation and the Bond Indenture. The joint and several obligation described herein of each Member of the Obligated Group to pay amounts due under the Series 2015 Obligation may not be enforceable under any of the following circumstances:

(i) to the extent payments on the Series 2015 Obligation are requested to be made from assets of a Member which are donor-restricted or which are subject to a direct, express or charitable trust that does not permit the use of such assets for such payments;

(ii) if the purpose of the debt created and evidenced by the Series 2015 Obligation is not consistent with the charitable purposes of the Member from which such payment is requested or required, or if the debt was incurred or issued for the benefit of an entity other than a nonprofit corporation that is

exempt from federal income taxes under sections 501(a) and 501(c)(3) of the Code and is not a "private foundation" as defined in section 509(a) of the Code;

(iii) to the extent payments on the Series 2015 Obligation would result in the cessation or discontinuation of any material portion of the health care or related services previously provided by such Member; or

(iv) if and to the extent payments are requested to be made pursuant to any loan violating applicable usury laws.

These limitations on the enforceability of the joint and several obligations of the Members of the Obligated Group on the Series 2015 Obligation also apply to their obligations on all Obligations. If the obligation of a particular Member of the Obligated Group to make payment on an Obligation is not enforceable and payment is not made on such Obligation when due in full, then Events of Default will arise under the Master Indenture.

In addition, common law authority and authority under state statutes exists for the ability of courts in such states to terminate the existence of a nonprofit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purposes. Such court action may arise on the court's own motion or pursuant to a petition of the attorney general of such states or such other persons who have interests different from those of the general public, pursuant to the common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

The legal right and practical ability of the Bond Trustee to enforce its rights and remedies against Allina Health under the Bond Indenture and related documents and to enforce its rights and remedies against Obligated Group Members under the Security Agreement and the Series 2015 Obligation may be limited by laws relating to bankruptcy, insolvency, reorganization, fraudulent conveyance or moratorium and by other similar laws affecting creditors' rights. In addition, the Bond Trustee's ability to enforce such terms will depend upon the exercise of various remedies specified by such documents which may in many instances require judicial actions that are often subject to discretion and delay or that otherwise may not be readily available or may be limited.

The various legal opinions delivered concurrently with the issuance of the Bonds will be qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws, rulings, policy and decisions affecting available remedies and by bankruptcy, reorganization or other laws of general application affecting the enforcement of creditors' rights, including fraudulent conveyance considerations, or the enforceability of certain remedies or document provisions.

For a further description of the provisions of the Bond Indenture, the Security Agreement and the Master Indenture, including covenants that secure the Bonds, events of default, acceleration and remedies, see APPENDIX C – "DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS."

Transfers From Other Credit Group Members. The Master Indenture obligates each Obligated Group Member to cause each Designated Affiliate and each Limited Designated Affiliate it controls and each Unlimited Credit Group Participant and Limited Group Participant with which it has entered into a contract or agreement to pay or otherwise transfer to the Obligated Group Agent or other Obligated Group Member such amounts as are necessary for payment pursuant to Obligations. There can be no assurance, however, of the extent or adequacy of such control or the ability of a controlling Member to exercise this control. See "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement – The Credit Group." For example, an Obligated Group Member may not be able to enforce the transfer of funds from a member of the Credit Group that is a not-for-profit corporation to pay debt service to the extent such funds (i) are requested to make payments on any Obligation which is issued for a purpose not consistent with the charitable purposes of the Credit Group Member from which such transfer is requested or which is issued for the benefit of any entity other than a tax-exempt organization; (ii) are requested to be made from any property which is donor restricted or which is subject to a direct or express trust which does not permit the use of such property for such payments; or (iii) would result in the cessation or discontinuation of any material portion of the healthcare or related charitable services previously provided by a Credit Group Member from which such payment is requested. Since neither the identity of particular Credit Group

Members from whom funds will be requested, the amount of such requested funds, the charitable purposes of such Credit Group Members, if applicable, nor their financial conditions and available funds when an Obligated Group Member makes the request for a transfer of funds can presently be determined, the extent to which the property of any Credit Group Member may fall within any of the categories referred to above cannot be determined and could be substantial.

There is no clear precedent in the law as to whether transfers from a member of the Credit Group in order to pay debt service on the Obligations issued for the benefit of another member of the Credit Group may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring member of the Credit Group or by creditors of the transferring member of the Credit Group in an action brought pursuant to fraudulent conveyances or similar state statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under fraudulent conveyances statutes, a creditor of a guarantor, may avoid any obligation incurred by a guarantor, if, among other bases therefor, (i) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (ii) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or fraudulent conveyances statutes, or the guarantor is undercapitalized.

Application by courts of tests of "insolvency," "reasonably equivalent value" and "fair consideration" has resulted in a conflicting body of case law. It is possible that, in an action to force a member of the Credit Group to transfer funds to the Obligated Group to permit Allina Health to pay debt service on Obligations issued for the benefit of another member of the Credit Group, a court might not permit such a transfer in the event it is determined that the member of the Credit Group is analogous to a guarantor, that fair consideration or reasonably equivalent value for such guaranty was not received and that the transfer will render the member of the Credit Group insolvent or such member is or will thereby become undercapitalized.

There exists common law authority and authority under certain statutes for the ability of the courts to terminate the existence of a nonprofit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purposes. Such court action may arise on the court's own motion or pursuant to a petition of the state Attorney General or such other persons who have interests different from those of the general public, pursuant to the common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

Bankruptcy. In the event of bankruptcy of a Member of the Obligated Group, the rights and remedies of the Holders of Obligations, including the Series 2015 Obligation, are subject to various provisions of the Federal Bankruptcy Code, which could adversely affect the Owners or beneficial owners of the Bonds. See "BONDHOLDERS' RISKS – Other Risk Factors – Bankruptcy and Insolvency" herein.

Unsecured Debt. In addition, the obligations of Allina Health under the Bond Indenture and of Allina Health and any future Members under the Master Indenture are not secured by a lien on or security interest in any assets or revenues of the Members, other than the lien on Pledged Revenues described under the caption "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement – Security Agreement" and " – Security Interest in Pledged Revenues" above. Except with respect to the lien on Pledged Revenues, in the event of a bankruptcy of Allina Health or any other future Members, Bondholders would be unsecured creditors and would be in an inferior position to any secured creditors and on parity with all other unsecured creditors.

ANNUAL DEBT SERVICE REQUIREMENTS

The following table sets forth, for each year ending on December 31, the amounts required to be paid by Allina Health with respect to principal, whether by payment at maturity or upon mandatory sinking account redemption, and interest on the Bonds and other long-term debt indebtedness of the Obligated Group. See also, APPENDIX A – "ALLINA HEALTH SYSTEM – FINANCIAL INFORMATION – Capitalization" and "– Debt Service Coverage Ratios" and "– INVESTMENT MANAGEMENT – Debt and Swap Structure."

	The Bonds				
Year Ending December 31	Principal	Interest	Total Debt Service	Other Debt Service[1]	Aggregate Debt Service
2015	--	$ 1,968,715.28	$ 1,968,715.28	$ 49,513,172.78	$ 51,481,888.06
2016	--	12,012,500.00	12,012,500.00	50,341,072.34	62,353,572.34
2017	--	12,012,500.00	12,012,500.00	50,152,271.96	62,164,771.96
2018	--	12,012,500.00	12,012,500.00	50,013,773.30	62,026,273.30
2019	--	12,012,500.00	12,012,500.00	50,050,751.15	62,063,251.15
2020	--	12,012,500.00	12,012,500.00	50,090,993.86	62,103,493.86
2021	--	12,012,500.00	12,012,500.00	50,030,162.10	62,042,662.10
2022	--	12,012,500.00	12,012,500.00	49,441,430.72	61,453,930.72
2023	--	12,012,500.00	12,012,500.00	49,521,706.00	61,534,206.00
2024	--	12,012,500.00	12,012,500.00	49,436,629.00	61,449,129.00
2025	--	12,012,500.00	12,012,500.00	47,174,150.50	59,186,650.50
2026	--	12,012,500.00	12,012,500.00	47,184,552.50	59,197,052.50
2027	--	12,012,500.00	12,012,500.00	47,195,418.00	59,207,918.00
2028	--	12,012,500.00	12,012,500.00	47,252,765.50	59,265,265.50
2029	--	12,012,500.00	12,012,500.00	43,513,053.00	55,525,553.00
2030	--	12,012,500.00	12,012,500.00	43,467,502.00	55,480,002.00
2031	--	12,012,500.00	12,012,500.00	43,497,361.00	55,509,861.00
2032	--	12,012,500.00	12,012,500.00	43,523,258.00	55,535,758.00
2033	--	12,012,500.00	12,012,500.00	40,975,178.00	52,987,678.00
2034	--	12,012,500.00	12,012,500.00	41,022,628.00	53,035,128.00
2035	--	12,012,500.00	12,012,500.00	41,045,611.00	53,058,111.00
2036	--	12,012,500.00	12,012,500.00	--	12,012,500.00
2037	--	12,012,500.00	12,012,500.00	--	12,012,500.00
2038	--	12,012,500.00	12,012,500.00	--	12,012,500.00
2039	--	12,012,500.00	12,012,500.00	--	12,012,500.00
2040	--	12,012,500.00	12,012,500.00	--	12,012,500.00
2041	$50,000,000.00	12,012,500.00	62,012,500.00	--	62,012,500.00
2042	50,000,000.00	9,610,000.00	59,610,000.00	--	59,610,000.00
2043	50,000,000.00	7,207,500.00	57,207,500.00	--	57,207,500.00
2044	50,000,000.00	4,805,000.00	54,805,000.00	--	54,805,000.00
2045	50,000,000.00	2,402,500.00	52,402,500.00	--	52,402,500.00
	$250,000,000.00	$338,318,715.28	$588,318,715.28	$984,443,440.71	$1,572,762,155.99

[1] Interest on debt currently bearing interest at a variable rate is based on the interest rate of the associated swap or 3.5%.

BONDHOLDERS' RISKS

The purchase of the Bonds involves investment risks that are discussed throughout this Offering Memorandum. Each prospective purchaser of the Bonds should evaluate all of the information presented in this Offering Memorandum to make an informed investment decision. This section on Bondholders' risks focuses primarily on the general risks associated with hospital or health system operations; whereas APPENDIX A describes Allina Health and its subsidiaries specifically. These should be read together. The operations and financial condition of Allina Health and its subsidiaries may be affected by factors other than those described in this section on Bondholders' risks and elsewhere in this Offering Memorandum. No assurance can be given as to the nature of such factors or the potential effects thereof on Allina Health.

General

As set forth under "SECURITY FOR THE BONDS" herein, Allina Health is obligated to pay when due payments that are required to be at least equal to the principal of, redemption price, including Make-Whole Redemption Price (if any), and interest, on the Bonds pursuant to the Bond Indenture. Allina Health's obligation to make payments with respect to the Bonds will be further evidenced and secured by the Series 2015 Obligation issued under the Master Indenture. All Obligations issued and Outstanding under the Master Indenture are secured by a grant of security interest in Pledged Revenues. No representation or assurance can be made that revenues will be realized by, or available to, Allina Health in amounts sufficient to make the payments pursuant to the Bond Indenture or by Allina Health and any future Members of the Obligated Group to make payments pursuant to the Series 2015 Obligation and, consequently, payment of debt service on the Bonds. For a description of certain limitations on enforceability of the Master Indenture, the Security Agreement, the Bond Indenture, the lien on Pledged Revenues and other similar matters, see "SECURITY FOR THE BONDS – Limitations on Enforceability" herein.

Allina Health is subject to a wide variety of federal and state regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare, Medicaid and other payers and is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("DHHS"), and other federal, state and local government agencies. The future financial condition of Allina Health could be adversely affected by, among other things, changes in the method, timing and amount of payments for health care services to Allina Health by governmental and nongovernmental payers, the financial viability of these payers, increased competition from other health care entities, demand for health care, other forms of care or treatment, changes in the methods by which employers purchase health care for employees, capability of management, changes in the structure of how health care is delivered and paid for (e.g., a single payer system or accountable care organizations), future changes in the economy, demographic changes, availability of physicians, nurses and other health care professionals, and malpractice claims and other litigation. These factors and others may adversely affect both payment by Allina Health under the Bond Indenture and payment by Allina Health and any future Members of the Obligated Group under the Series 2015 Obligation and, consequently, payment of debt service on the Bonds. In addition, the tax-exempt status of Allina Health could be adversely affected by, among other things, an adverse determination by a governmental entity, noncompliance with governmental regulations, or legislative changes.

Nonprofit Healthcare Environment

Allina Health is a nonprofit corporation, exempt from federal income taxation as an organization described in Section 501(c)(3) of the Code. As a nonprofit, tax-exempt organization, Allina Health is subject to federal, state and local laws, regulations, rulings and court decisions relating to its organization and operation, including its operation for charitable purposes. At the same time, Allina Health conducts large-scale complex business transactions and Allina Health is often a major employer in the geographic areas where it operates. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex, multi-facility healthcare organization.

The operations or practices of nonprofit, tax-exempt health care providers have been routinely challenged or questioned to determine if they are consistent with the regulatory requirements for, and societal expectations of, nonprofit, tax-exempt organizations. These challenges, in some cases, are broader than concerns about compliance

with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the health care organizations. Areas that have come under examination have included pricing practices, billing and collection practices, charitable care, methods of providing and reporting community benefit, executive compensation, exemption of property from real property taxation and private use of facilities financed with tax-exempt obligations. These challenges and questions have come from many sources, including state attorneys general, the Internal Revenue Service (the "IRS"), labor unions, Congress, state legislatures, taxpayer groups, the press and patients, and in many forums, including hearings, audits and litigation. These challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on Allina Health.

Congressional Hearings. Senate and House committees have conducted several nationwide investigations of hospital billing and collection practices and prices charged to uninsured patients and have considered reforms to the nonprofit sector, including proposed reform in the area of tax-exempt health care organizations, as part of health care reform generally. See "*IRS Examinations of Compensation Practices and Community Benefit Practices*" below.

Tax-Exempt Bond Examinations. IRS officials have indicated that more resources will be invested in audits of tax-exempt bonds in the charitable organization sector with specific review of private use. A schedule to the revised Form 990 return (Schedule K), effective for the 2009 tax year and thereafter, is intended to address what the IRS believes is significant noncompliance with recordkeeping and record retention requirements for tax-exempt bonds. Schedule K also requires tax-exempt organizations to report on the investment and use of tax-exempt bond proceeds to address IRS concerns regarding compliance with arbitrage rebate requirements and the private use of tax-exempt bond-financed facilities. See "BONDHOLDERS' RISKS – Tax-Exempt Status and Other Tax Exemption; Tax Audits" below.

IRS Examinations of Compensation and Community Benefit Practices. In 2004, the IRS began a new compliance program to measure compliance by tax-exempt organizations with requirements that they not pay excessive compensation and benefits to their officers and other insiders. In February 2009, the IRS issued its Hospital Compliance Project Final Report (the "IRS Final Report") that examined tax-exempt organizations' practices and procedures with regard to compensation and benefits paid to their officers, directors, trustees, and key employees. An executive summary of the IRS Final Report indicates that the IRS will continue to heavily scrutinize executive compensation arrangements, practices and procedures of tax-exempt hospitals and other tax-exempt organizations.

The IRS has also undertaken a community benefit initiative directed at hospitals. The IRS Final Report determined that the reporting of community benefit by nonprofit hospitals varied widely, both as to types of programs and expenditures classified as community benefit and the measurement of community benefits. As a result, the IRS issued the revised Form 990 that includes Schedule H which is designed to provide uniformity regarding types of programs and expenditures reported as community benefit by nonprofit hospitals. As the IRS collects and reviews information from hospitals about the level and types of community benefit provided, the IRS may issue a more stringent interpretation of community benefit. Findings from Schedule H reports may also revive proposals in Congressional committees which, from time to time, have been made to codify the requirements for hospitals' tax-exempt status, including requirements to provide minimum levels of charity care. Tax-exempt organizations must complete Schedule J to Form 990, which requires reporting of compensation information for the organizations' current (and certain former) officers, directors, trustees, key employees, and highest compensated employees. Additionally, the ACA (as defined herein) contains new requirements for nonprofit hospitals in order to maintain their tax-exempt status.

Class Actions. Hospitals and health systems have long been subject to a wide variety of litigation risks, including liability for care outcomes, employer liability, property and premises liability, and peer review litigation with physicians, among others. In recent years, consumer class action litigation has emerged as a potentially significant source of litigation liability for nonprofit hospitals and health systems. These class action suits have most recently focused on hospital billing and collections practices and breaches of privacy, and they may be used for a variety of currently unanticipated causes of action. Since the subject matter of class action suits may involve uninsured risks, and since such actions often involve alleged large classes of plaintiffs, they may have material adverse consequences on hospitals and health systems in the future.

Indigent Care. Tax-exempt health care providers often treat large numbers of indigent patients who are unable to pay in full for their medical care. Typically, urban, inner-city hospitals and other health care providers may treat significant numbers of indigents. These hospitals and health care providers may be susceptible to economic and political changes that could increase the number of indigents or their responsibility for caring for this population. General economic conditions affect the number of employed individuals who have health coverage and the ability of patients to pay for their care. Similarly, changes in governmental policy, which may result in coverage exclusions under local, county, state and federal health care programs (including Medicare and Medicaid) may increase the frequency and severity of indigent treatment by such hospitals and other providers. It also is possible that future legislation could require that tax-exempt hospitals and other providers maintain minimum levels of indigent care as a condition to federal income tax exemption or exemption from certain state or local taxes. In addition, the Minnesota Attorney General has conducted a number of reviews of the policies and practices of Minnesota hospitals with regard to their provision of charity care and their collection practices. As a result of those audits, most hospitals in Minnesota, including Allina Health, have agreed to follow certain policies and practices with regard to charity care, discounts for self-pay members, and collections. The agreements provide that the hospital must limit the amounts charged for medically necessary care to uninsured individuals to not more than the hospital would be reimbursed for that service by the insurance company providing the hospital with the most revenue in the previous calendar year and that the hospital must not engage in certain collection actions until a debt is authorized by an accountable employee of the hospital upon verification of certain information.

Litigation Relating to Billing and Collection Practices. Lawsuits have been filed in both federal and state courts alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. The cases are proceeding in various courts around the country with inconsistent results. While it is not possible to make general predictions, some hospitals and health systems have incurred substantial costs in defending such lawsuits and in some cases have entered into substantial settlements.

Challenges to Real Property Tax Exemptions. The real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities have been challenged on the grounds that the health care providers were not engaged in sufficient charitable activities. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices, excessive financial margins and operations that too closely resemble for-profit businesses. A recent decision by a tax court in New Jersey stated that a New Jersey tax-exempt hospital was not entitled to state property tax exemption and one of the factors the court considered in making this determination was the entangled nature of the hospital's for-profit and nonprofit affiliates. While a New Jersey tax court decision is not applicable to Minnesota non-profit hospitals it is an example that could be copied by state taxing authorities in other states.

The foregoing are some examples of the challenges and examinations facing nonprofit health care organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations and may indicate an increasingly difficult operating environment for nonprofit health care organizations, including Allina Health. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on hospitals and health care providers, including Allina Health, and, in turn, the ability of Allina Health to make payments under the Bond Indenture and of Allina Health or future Members of the Obligated Group to make payments under the Series 2015 Obligation, and consequently, payment of debt service on the Bonds.

Federal Budget Matters

American Recovery and Reinvestment Act of 2009. In February 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 ("ARRA"). ARRA includes several provisions that are intended to provide financial relief to the health care sector, including a requirement that states promptly reimburse health care providers. ARRA also established a framework for the implementation of a nationally-based health information technology program, including incentive payments commencing in 2011 to eligible health care providers to encourage implementation of health information technology and electronic health records. For more information on this program, see "BONDHOLDERS' RISKS – Regulatory Environment – The HITECH Act" below.

Federal Budget Cuts. The Budget Control Act of 2011 (the "BCA") mandates significant reductions and spending caps on the federal budget for fiscal years 2012-2021. The BCA also created a Joint Select Committee on Deficit Reduction (the "Super Committee") to develop a plan to further reduce the federal deficit by at least $1.5 trillion on or before November 23, 2011. Because the Super Committee failed to act, the debt ceiling was to be automatically raised and sequestration (the process of automatic across the board cuts) was to be triggered in an amount necessary to achieve $1.2 trillion in savings to take effect on January 2, 2013. A wide range of spending is exempted from sequestration, including: Social Security, Medicaid, Veteran's programs, specified federal retirement funds, child nutrition, and other programs. Medicare was not exempted from sequestration, but Medicare payment reductions were to be limited to 2% of total program costs.

The American Taxpayer Relief Act of 2012 ("ATRA") postponed this scheduled reduction until March 1, 2013 and the 2% Medicare spending reduction ultimately took effect for services provided on or after April 1, 2013. Additionally, ATRA significantly affects hospital Medicare reimbursement in that it requires the Medicare program to recoup funds from hospitals based on changes in documentation and coding that have increased Medicare inpatient prospective payment system ("IPPS") payments but that do not represent real increases in the intensity of services provided to patients.

In December 2013, the Bipartisan Budget Act of 2013 was enacted, which, among other actions, extended the 2% reduction in Medicare spending through 2023.

Additionally, federal health care reform legislation has also resulted in significant reimbursement cuts. See "Health Care Reform – Federal Health Care Reform" below for additional information.

It is possible that Congress will take action to eliminate some or all of the reductions in the future and any Congressional action could be made retroactive in order to eliminate some or all of the cuts even to the extent they were imposed. However, there is no certainty that Congress will take any action. Absent further Congressional action, these automatic spending cuts will become permanent. Because Congress may make changes to the budget in the future, it is impossible to predict the effect any spending cuts may have upon Allina Health. Similarly, it is impossible to predict whether any automatic reductions to Medicare may be triggered in lieu of other spending cuts that may be proposed by Congress. If and to the extent Medicare and/or Medicaid spending is reduced under either scenario, this may have a material adverse effect upon the financial condition of Allina Health. Ultimately, these reductions or alternatives could have a disproportionate impact on hospital providers and could have an adverse effect on the financial condition of Allina Health, which could be material.

Debt Limit Increase. Through legislation, the federal government has created a debt "ceiling" or limit on the amount of debt that may be issued by the United States Treasury. In the past several years, political disputes have arisen within the federal government in connection with discussions concerning the authorization for an increase in the federal debt ceiling. Any failure by Congress to increase the federal debt limit may impact the federal government's ability to incur additional debt, pay its existing debt instruments and to satisfy its obligations relating to the Medicare and Medicaid programs.

Management of Allina Health is unable to determine at this time what impact any future failure to increase the federal debt limit may have on the operations and financial condition of Allina Health, although such impact may be material. Additionally, the market price or marketability of the Bonds in the secondary market may be materially adversely impacted by any failure of Congress to increase the federal debt limit.

State Budget Matter

States may, from time to time, and many states have in recent years, faced severe financial challenges, which included erosion of general fund tax revenues. These factors often resulted in a shortfall between revenue and spending demands. Financial challenges facing states may negatively affect providers in such states in a number of ways, including, but not limited to, a decrease in the percentage of patients who have private insurance, a greater number of indigent patients who are unable to pay for their care and a greater number of individuals who qualify for Medicaid and/or reductions in Medicaid reimbursement rates. These factors may materially increase costs of operations for Allina Health.

Health Care Reform

Federal Health Care Reform. The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as "ACA") were enacted in March 2010. The ACA addresses almost all aspects of hospital and provider operations and health care delivery, and has changed and is changing how health care services are covered, delivered and reimbursed. These changes will result in new payment models with the risk of lower health care provider reimbursement from Medicare, utilization changes, increased government enforcement and the necessity for health care providers to assess, and potentially alter, their business strategy and practices, among other consequences. While many providers will receive reduced payments for care, millions of previously uninsured Americans may have coverage. State "health insurance exchanges" could fundamentally alter the health insurance market and negatively impact health care providers, for example, by enabling insurers to aggressively negotiate rates. Federal deficit reduction efforts will likely curb federal Medicare and Medicaid spending further to the detriment of hospitals, physicians and other health care providers.

As a result of the ACA, substantial changes have occurred and are anticipated to occur in the United States health care system. The ACA is impacting the delivery of health care services, the financing of health care costs, reimbursement of health care providers and the legal obligations of health insurers, providers, employers and consumers. Some of the provisions of the ACA took effect immediately or within a few months of final approval, while others were or will be phased in over time, ranging from one year to ten years. Because of the complexity of the ACA generally, additional legislation will likely be considered and enacted over time. The ACA has also required, and will continue to require, the promulgation of substantial regulations with significant effects on the health care industry. Thus, the health care industry is the subject of significant new statutory and regulatory requirements and consequently to structural and operational changes and challenges for a substantial period of time. The full ramifications of the ACA may also become apparent only over time and through later regulatory and judicial interpretations. Portions of the ACA have already been limited and nullified as a result of legislative amendments and judicial interpretations and future actions may further change its impact. The uncertainties regarding the implementation of the ACA create unpredictability for the strategic and business planning efforts of health care providers, which in itself constitutes a risk.

Efforts to repeal provisions of the ACA are from time to time pending in Congress. In June 2012, the U.S. Supreme Court upheld most provisions of the ACA, while limiting the power of the federal government to penalize states for refusing to expand Medicaid, and on June 25, 2015, the Supreme Court ruled that health insurance subsidies under the ACA would be available in all states, including those with a federally-facilitated health insurance exchange. At this time it is not possible to predict the outcomes of any legislative attempts to repeal or amend the ACA or any further judicial interpretations of the ACA.

The changes in the health care industry brought about by the ACA may have both positive and negative effects, directly and indirectly, on the nation's hospitals and other health care providers, including Allina Health. For example, the projected increase in the numbers of individuals with health care insurance occurring as a consequence of Medicaid expansion, creation of health insurance exchanges, subsidies for insurance purchase and the penalty on certain individuals who do not purchase insurance could result in lower levels of bad debt and increased utilization or profitable shifts in utilization patterns for hospitals. However, the cost containment measures and pilot programs that the ACA requires, the extent to which Medicaid expansion, which is now optional on a state by state basis, is either not pursued or results in a shifting of significant numbers of commercially-insured individuals to Medicaid, or health insurance options on exchanges are limited or unaffordable, may offset these benefits. A negative impact to the hospital industry overall will likely result from scheduled cumulative reductions in Medicare payments; such reductions may be substantial. The ACA's cost-cutting provisions to the Medicare program include reduction in Medicare market basket updates to hospital reimbursement rates under the IPPS, additional reductions to or elimination of Medicare reimbursement for certain patient readmissions and hospital-acquired conditions, as well as anticipated reductions in rates paid to Medicare managed care plans that may ultimately be passed on to providers. Industry experts also expect that government cost reduction actions may be followed by private insurers and payers. The reductions may have a material impact, and could offset any positive effects of the ACA.

Health care providers could be further subjected to decreased reimbursement as a result of implementation of recommendations of the Independent Payment Advisory Board ("IPAB"). In the event that the projected

Medicare per capita growth rate exceeds a target growth rate in any year, IPAB is directed to make recommendations for cost reduction, and those recommended reductions will be automatically implemented unless Congress adopts alternative legislation that meets equivalent Medicare savings targets. While hospitals are largely exempted from recommendations from the IPAB until 2020, industry experts also expect that government cost reduction actions may be followed by private insurers and payers. The Chief Actuary of CMS has concluded that the projected Medicare per capita growth rate has not yet exceeded the target growth rate and there will be no need for IPAB activity at least through 2016.

Beginning in 2014, the ACA authorized the creation of state "health insurance exchanges" in which health insurance can be purchased by certain groups and segments of the population, expanded the availability of subsidies and tax credits for premium payments by some consumers and employers, and required that certain terms and conditions be included by commercial insurers in contracts with providers. In addition, the ACA imposed many new obligations on states related to health insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect Allina Health. The health insurance exchanges may affect hospitals positively by increasing the availability of health insurance to individuals who were previously uninsured. Conversely, employers or individuals may shift their purchase of health insurance to new plans offered through the exchanges, which may or may not reimburse providers at rates equivalent to rates the providers currently receive. The exchanges could alter the health insurance markets in ways that cannot be predicted, and exchanges might, directly or indirectly, take on a rate-setting function that could negatively impact providers. Because the exchanges are still so new, the effects of these changes upon the financial condition of any third-party payer that offers health insurance, rates paid by third-party payers to providers and, thus, the revenues of Allina Health, and upon the operations, results of operations and financial condition of Allina Health, cannot be predicted.

High deductible insurance plans have become more common in recent years, and the ACA is expected to encourage the increase in high deductible insurance plans as the health care exchanges include a variety of plans, several of which offer lower monthly premiums in return for higher deductibles. Many plans offered on the exchanges have high deductibles. High deductible plans may contribute to lower inpatient volumes as patients may forgo or choose less expensive medical treatment to avoid having to pay the costs of the high deductibles. There is also a potential concern that some patients with high deductible plans will not be able to pay their medical bills as they may not be able to cover their high deductible.

The ACA will likely affect some health care organizations differently from others, depending, in part, on how each organization adapts to the legislation's emphasis on directing more federal health care dollars to integrated provider organizations and providers with demonstrable achievements in quality care. The ACA proposes a value-based purchasing system for hospitals under which a percentage of Medicare payments will be contingent on satisfaction of specified performance measures related to common and high-cost medical conditions, such as cardiac, surgical and pneumonia care. The ACA also funds various demonstration programs and pilot projects and other voluntary programs to evaluate and encourage new provider delivery models and payment structures, including "accountable care organizations" ("ACOs") and bundled provider payments. On January 26, 2015, DHHS announced a timetable for transitioning Medicare payments from the traditional fee-for-service model to a value-based payment system. This schedule calls for tying 30% of traditional Medicare fee-for-service payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements, by the end of 2016, increasing to 50% by 2018. In addition, DHHS proposed that by 2016, 85% of all traditional Medicare fee-for service payments have a component based on quality or value, increasing to 90% by 2018. As of the date of such announcement, approximately 20% of Medicare's payments were made through alternative payment models, up from almost none in 2011. The outcomes of these projects and programs, including the likelihood of being made permanent or expanded or their effect on health care organizations' revenues or financial performance, cannot be predicted.

The ACA expands access to Medicaid and the scope of services covered thereunder. However, as stated above, the U.S. Supreme Court's decision made the decision to expand Medicaid an option for each state. In the event a state chooses not to participate in the expanded Medicaid program, the net effect of the reforms in the ACA could be significantly reduced. The State of Minnesota has chosen to expand Medicaid under the ACA. See "Minnesota Health Care Reform" below. The State of Wisconsin has presently not chosen to expand Medicaid under the ACA.

The ACA contains amendments to existing criminal, civil and administrative anti-fraud statutes and increases in funding for enforcement and efforts to recoup prior federal health care payments to providers. Under the ACA, a broad range of providers, suppliers and physicians are required to adopt a compliance and ethics program. While the government has already increased its enforcement efforts, failure to implement certain core compliance program features provides new opportunities for regulatory and enforcement scrutiny, as well as potential liability if an organization fails to prevent or identify improper federal health care program claims and payments. See also "BONDHOLDERS' RISKS – Regulatory Environment" below.

Minnesota Health Care Reform. On March 20, 2013, Governor Dayton signed into law Minnesota's health insurance exchange, called "MNsure." At that time, State officials projected that 1.3 million people would purchase insurance through MNsure. However, like the federal website, MNsure's October 1, 2013, website launch was plagued with technical problems and enrollment continues to fall below projections. Support among State legislators had waned for MNsure and there were threats to end MNsure in 2017. However, in May 2015, a bill was passed and signed into law to establish a task force to advise the governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans, including examining the future of MNsure, Medical Assistance, MinnesotaCare (the State's subsidized health insurance program for working Minnesotans without access to affordable health care) and the chance for federal waivers that could allow for a broad range of health care reforms.

Patient Service Revenues

Net patient revenues realized by Allina Health are derived from a variety of sources and will vary among the individual facilities owned and operated by Allina Health. Certain facilities and regions may realize substantially more revenues from private payment programs, such as managed care organizations, than do others.

A substantial portion of the net patient service revenues of Allina Health is derived from third-party payers which pay for the services provided to patients covered by third parties for services. These third-party payers include the federal Medicare program, state Medicaid programs and private health plans and insurers, including health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). Many of those programs make payments to Allina Health in amounts that may not reflect the direct and indirect costs of Allina Health of providing services to patients.

The financial performance of Allina Health has been and could be in the future adversely affected by the financial position or the insolvency or bankruptcy of or other delay in receipt of payments from third-party payers that provide coverage for services to their patients.

The Medicare Program. Medicare is a federal governmental health insurance system under which physicians, hospitals and other health care providers or suppliers are reimbursed or paid directly for services provided to eligible elderly persons, disabled persons and persons with end-stage renal disease. Medicare is administered by CMS, an operating division of DHHS. In order to achieve and maintain Medicare certification, certain health care providers, including hospitals, must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state in which the provider is located, and/or ongoing compliance with standards of a chosen accreditation program, such as The Joint Commission or the Healthcare Facilities Accreditation Program. In Minnesota, the Minnesota Department of Health is the state agency responsible for surveying hospitals on behalf of CMS to determine whether they comply with the Conditions of Participation. Failure to comply with the Conditions of Participation could have a materially adverse effect on the continued participation in the Medicare and Medicaid programs, and ultimately, the revenues of Allina Health. See "BONDHOLDERS' RISKS – Regulatory Environment – Compliance with Conditions of Participation" for additional information regarding Conditions of Participation.

Allina Health depends significantly on Medicare as a source of revenue. For the fiscal years ended December 31, 2012, 2013 and 2014, Medicare payments represented approximately 28%, 29% and 29% of Allina Health's net patient service revenue. See APPENDIX A – "ALLINA HEALTH SYSTEM – FINANCIAL INFORMATION – Managed Care Relationships." Because of this dependence, changes in the Medicare program may have a material effect on Allina Health. As the population ages, more people will become eligible for the Medicare program. Current projections indicate that demographic changes and continuation of current cost trends

will exert significant and negative forces on the overall federal budget. Generally, the Medicare program reimburses hospitals based on a fixed schedule of rates based on categories of treatments or conditions. These rates change over time and there is no assurance that these rates will cover the actual costs of providing services to Medicare patients. Further, it is anticipated there will be reductions in rates paid to Medicare managed care plans that may ultimately be passed on to providers.

Market Basket Reductions. Generally, Medicare payment rates to hospitals are adjusted annually based on a "market basket" of estimated cost increases, which have averaged approximately 2-3% annually in recent years. The ACA required automatic 0.25% reductions in the "market basket" for federal fiscal years 2010 and 2011, and calls for reductions ranging from 0.10% to 0.75% each year through federal fiscal year 2019.

Market Productivity Adjustments. Beginning in federal fiscal year 2012 and thereafter, the ACA provides for "market basket" adjustments based on overall national economic productivity statistics calculated by the Bureau of Labor Statistics.

Value-Based Purchasing. Beginning in federal fiscal year 2013, Medicare inpatient payments to hospitals are determined, in part, based on a program under which value-based incentive payments are made in a fiscal year to hospitals that meet certain performance standards during that fiscal year. The program is funded through the reduction of hospital inpatient care payment by 1% in federal fiscal year 2013, progressing to 2% by federal fiscal year 2017. This reduction may be offset by incentive payments that commenced in federal fiscal year 2013 for hospitals that meet or exceed quality standards. The fiscal year 2015 federal budget proposes to implement an expanded value-based purchasing program, which would include providers beyond those currently participating in value-based purchasing initiatives, and would tie at least 2% of payments to quality and efficiency of care requirements for hospital outpatient departments.

Hospital Acquired Conditions Penalty. Beginning in federal fiscal year 2015, Medicare inpatient payments to hospitals that are in the top quartile nationally for frequency of certain "hospital-acquired conditions" identified by CMS will be reduced by 1% of what would otherwise be payable to each hospital for the applicable federal fiscal year.

Readmission Rate Penalty. Beginning in federal fiscal year 2013, Medicare inpatient payments to those hospitals with excess readmissions compared to the national average for three patient conditions (acute myocardial infarction, pneumonia and heart failure) are reduced based on the dollar value of that hospital's percentage of excess preventable Medicare readmissions within 30 days of discharge. The maximum penalty was 1% in federal fiscal year 2013, increasing to 3% in fiscal year 2015. In fiscal year 2015, CMS is expanding the patient conditions assessed for this penalty to include acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty.

Medicare Advantage. Hospitals also receive payments from health plans under the Medicare Advantage program. The ACA includes significant changes to federal payments to Medicare Advantage plans resulting in a transition to benchmark payments tied to the level of fee-for-service spending in the applicable county. Decreased federal payments to the Medicare Advantage plans could in turn affect the scope of coverage of these plans or cause plan sponsors to negotiate lower payments to providers.

Electronic Health Information Systems Medicare Incentive Payments and Payment Reductions. Components of ARRA provide for Medicare incentive payments, which began in 2011, to hospital providers meeting designated deadlines for the installation and use of electronic health information systems. For those hospital providers failing to meet the applicable deadline, Medicare payments will be significantly reduced. See also "BONDHOLDERS' RISKS – Regulatory Environment – The HITECH Act" below.

Hospital Inpatient Reimbursement. Hospitals are generally paid for inpatient services provided to Medicare beneficiaries based on established categories of treatments or conditions known as diagnosis related groups ("DRGs"). The actual cost of care, including capital costs, may be more or less than the

DRG rate. DRG rates are subject to adjustment by CMS, including reductions mandated by the ACA and the BCA, and are subject to federal budget considerations. There is no guarantee that DRG rates, as they change from time to time, will cover actual costs of providing services to Medicare patients. For information regarding the impact of the ACA on payments to hospitals for inpatient services, see "The Medicare Program – Market Basket Reductions" above.

Effective October 1, 2013, CMS adopted a policy known as the Inpatient Hospital Prepayment Review "Probe & Educate" review process, or the "Two-Midnight" rule. The "Two-Midnight" policy specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. With some exceptions, stays not expected to extend past two midnights should not be admitted and instead be billed as outpatient. CMS adopted the policy due to growing concern with the overuse of the "observation status" at hospitals; CMS found that Medicare beneficiaries were spending extended periods of time in observation units without being admitted as inpatients. On January 31, 2014, CMS issued a notice delaying enforcement of the "Two-Midnight" rule until September 30, 2014. The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") extended the enforcement moratorium on the "Two-Midnight" rule through the end of fiscal year 2015. As a result, Medicare Recovery Audit Contractors will not audit inpatient hospital claims from October 1, 2013 through September 30, 2015, absent evidence of systematic gaming, fraud, abuse, or delays in the provisions of care. On July 1, 2015, CMS released proposed updates to the "Two-Midnight" rule. Under these proposals, an inpatient admission for stays expected to last less than two midnights, would be acceptable on a case-by-case basis, depending on the judgment of the physician and the documentation justifying the stay. Additionally, enforcement of the "Two-Midnight" rule would shift from Medicare Recovery Audit Contractors to Quality Improvement Organizations. The final rule is expected to be issued on or around November 1, 2015.

On October 31, 2014, CMS issued the Medicare Outpatient Prospective Payment System ("OPPS") Final Rule for calendar year 2015. Previously, as a condition of payment for hospital inpatient services, CMS required a physician certification, including an admission order and certain additional elements, for all inpatient admissions. The 2015 OPPS final rule implemented a change to the requirement that certifications must be provided for all inpatient admissions. Going forward, CMS will require physician certification only for outlier cases and long-stay cases of 20 days or more. An admission order will continue to be required for all inpatients when that patient has been formally admitted to the hospital. The effect of the "Two-Midnight" rule on Allina Health's operations is still unclear but it may have an adverse financial impact.

Hospital Outpatient Reimbursement. Hospitals are generally paid for outpatient services provided to Medicare beneficiaries under OPPS, which is based on established categories of treatments or conditions known as ambulatory payment classifications ("APC"). The actual cost of care, including capital costs, may be more or less than the reimbursements. The ACA provides for a reduction to the market basket used to determine annual OPPS increases by an adjustment factor for 2010 through 2019 and by a productivity adjustment for 2012 and subsequent years. Application of the productivity adjustment can result in a market basket increase of less than zero, such that payments in a current year may be less than the prior year. There is no guarantee that APC rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

Other Medicare Service Payments. Medicare payment for skilled nursing services, psychiatric services, inpatient rehabilitation services, and home health services are based on regulatory formulas or predetermined rates. There is no guarantee that these rates, as they may change from time to time, will be adequate to cover the actual cost of providing these services to Medicare patients.

Reimbursement of Hospital Capital Costs. Hospital capital costs apportioned to Medicare patient use (including depreciation and interest) are paid by Medicare on the basis of a standard federal rate (based upon average national costs of capital), subject to limited adjustments specific to the hospital. There can be no assurance that future capital-related payments will be sufficient to cover the actual capital-related costs

of Allina Health's facilities applicable to Medicare patient stays or will provide flexibility for hospitals to meet changing capital needs.

Medical Education Payments. Medicare currently pays for a portion of the costs of medical education at hospitals that have teaching programs. These payments are vulnerable to reduction or elimination. The direct and indirect medical education reimbursement programs have repeatedly emerged as targets in the legislative efforts to reduce the federal budget deficit. Legislation has capped the number of residents recognized by Medicare for reimbursement purposes and has limited reimbursement for both direct and indirect medical education costs. The President's fiscal year 2016 federal budget proposal included a $16 billion reduction in Medicare indirect medical education payments over 10 years, consistent with previous budget requests from the President's administration. Whether the proposed reductions in medical education payments will take effect is still unclear, but such reduction may have an adverse financial impact on Allina Health.

Medicare Bad Debt Reimbursement. Under Medicare, the costs attributable to the deductible and coinsurance amounts which remain unpaid by the Medicare beneficiary can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare Administrative Contractor ("MAC") from the prior cost report filing. Bad debts must meet the following criteria to be allowable:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to a program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35%. Amounts incurred by a hospital as reimbursement for bad debts are subject to audit and recoupment by the MAC. Bad debt reimbursement has been a focus of MAC audit/recoupment efforts in the past.

Physician Payments. Certain physician services are reimbursed on a national fee schedule called the "resource-based relative value scale" ("RBRVS"). Under the RBRVS system, payments for services are determined by the "resource costs" necessary to provide such services. Payments also are adjusted for geographical differences. The RBRVS fee schedule establishes payment amounts for physician services, including services of provider-based physicians, and is subject to annual updates. The Sustainable Growth Rate ("SGR"), which was a limit on the growth of Medicare payments for physician services, was linked to changes in the U.S. Gross Domestic Product over a ten-year period. SGR targets were compared to actual expenditures in order to determine subsequent physician fee schedule updates. Since 2003, Congress passed legislation to delay application of the SGR reductions, as payment under SGR methodology could have resulted in reductions to physician reimbursement exceeding 20%. Legislation had postponed the implementation of SGR cuts only until March 31, 2015. However, on April 16, 2015, President Obama signed into law MACRA to move the SGR program from a fee-for-service to a pay-for-performance model that would control the growth of physician payments based on clinical outcomes. MACRA will increase physician Medicare reimbursement by 0.5% annually until 2019 and then provide for no additional increases to base physician reimbursement through 2025. In addition to the base payment methodology, physicians could earn merit-based payments based on factors including compliance with meaningful use of electronic health records requirements and demonstration of quality-based medicine. Ultimately, it remains unclear what effect this legislation will have on Allina Health.

Recovery Audit Contractor Program. CMS has implemented a Recovery Audit Contractor ("RAC") program on a nationwide basis pursuant to which CMS contracts with private contractors to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. There is also a demonstration for RACs to conduct pre-payment reviews. The ACA expands the RAC program's scope to include managed Medicare plans and Medicaid claims. CMS also employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify improper payments. These programs tend to result in retroactively reduced payments and higher administration costs to hospitals.

The Medicaid Program. Medicaid is a health insurance program for certain low-income and needy individuals that is jointly funded by the federal government and the states. Pursuant to broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the payment rates for services; and administers its own programs.

Under the Medicaid program, the federal government supplements funds provided by the various states for medical assistance. Federal funding is provided to each state for its Medicaid program in the form of matching payments in amounts equal to a percentage of such state's Medicaid expenditures, ranging from 50% to 100%, depending upon the use of the funds and the per capita income of the state's recipients. These federal medical assistance percentages ("FMAPs") are recalculated for each federal fiscal year. Receipt of federal funding is contingent on a state Medicaid program's compliance with federal standards regarding beneficiary eligibility, coverage, benefits, and use of FMAP payments. Payment for medical and health services is made to providers in amounts determined in accordance with procedures and standards established by state law under federal guidelines. States may reimburse the costs of hospital services for Medicaid beneficiaries under each participating state's Medicaid program, within prescribed limits, to persons meeting certain minimum requirements. Allina Health receives substantial Medicaid reimbursements.

Fiscal considerations of both federal and state governments in establishing their budgets will directly affect the funds available to Allina Health and other providers for payment of services rendered to Medicaid beneficiaries and reimbursement of costs for hospital services to the uninsured. In the most recent fiscal year, the State of Minnesota enjoyed a budget surplus. However, financial challenges facing the State of Minnesota or the State of Wisconsin, from time to time, may negatively affect health care organizations in Minnesota or Wisconsin in a number of ways. The State of Minnesota or the State of Wisconsin may enact legislation designed to reduce Medicaid expenditures through eligibility restrictions, (causing a greater number of indigent, uninsured or underinsured patients) and reductions in Medicaid rates or other state health plan or related assistance payments. The ACA provides for significant expansions to the Medicaid program, and the BCA may shift further funding responsibility from the federal government to state governments, exacerbating any states' financial challenges.

The ACA makes changes to Medicaid funding and substantially increases the potential number of Medicaid beneficiaries. To fund this expansion, the ACA provides that the federal government will fund 100% of the costs of this expansion from 2014 – 2016, decreasing to 90% of the costs of this expansion in 2020 and thereafter. As mentioned above, in June 2012, the U.S. Supreme Court held that the federal government cannot withhold existing federal funds for states that refuse to expand Medicaid as required by the ACA. The State of Minnesota elected to expand Medicaid under the ACA and has taken steps accordingly to change its income eligibility guidelines in order to enable more people to qualify. The State of Wisconsin has not elected to expand Medicaid under the ACA. While management of Allina Health cannot predict the effect of these changes to the Medicaid program on operations, results from operations or financial condition of Allina Health, Medicaid has historically reimbursed at rates below the cost of care. Therefore, increases in the overall proportion of Medicaid patients poses a financial risk to Allina Health. It is uncertain to what extent this risk may be mitigated if the increased Medicaid utilization replaces previously uncompensated patients. Certain outcomes, such as a state refusing to expand Medicaid coverage, which includes the State of Wisconsin, which brings more patients to most hospital providers, while Medicaid payments cuts are implemented, could put providers at greater financial risk. At the same time, the State of Wisconsin's refusal to expand the Medicaid program could put providers at greater financial risk because the State of Wisconsin is unable to access federal funding associated with expansion, and current Medicaid rates are subject to reduction.

For the fiscal years ended December 31, 2012, 2013 and 2014, Allina Health received approximately 10%, 9% and 10%, respectively, of net patient service revenues from state Medicaid programs. See APPENDIX A – "ALLINA HEALTH SYSTEM – FINANCIAL INFORMATION – Managed Care Relationships." The growth in Medicaid expenditures in recent years has been augmented by the addition of the State's Children's Health Insurance Program in 1997, which provides health coverage to eligible children through Medicaid and separate programs. See "BONDHOLDERS' RISKS – Patient Service Revenues – State Children's Health Insurance Program" below for further information.

See also "BONDHOLDERS' RISKS – Health Care Reform – Minnesota Health Care Reform" above.

Minnesota Reimbursement Programs. Minnesota's Medicaid program, Medical Assistance ("MA"), is administered by the Minnesota Department of Human Services (the "Department"). However, in 1997 the Minnesota legislature modified MA to allow counties to serve as the administrator of the MA program in each county. Pursuant to the ACA, Minnesota expanded MA eligibility to almost all non-elderly adults meeting certain income thresholds. Under this program, enrollees do not have to pay premiums and MA covers most medical services. Minnesota also operates several Medicaid waiver programs that increase coverage across various patient populations including the elderly, the disabled and the chronically ill. The amount of MA reimbursement received by Allina Health in the future will depend on, among other things, fiscal considerations of both the federal and State of Minnesota governments in establishing their budgets for funding the MA program.

Inpatient hospital services covered by MA are prospectively established on a per admission or per day basis under a DRG system. Rates are differentiated by eligibility and specialty (Medicare designated rehabilitation unit and neonatal transfer) and long-term care hospital. The rate setting methodology is based on the cost-finding and allowable cost principles of the Medicare program. The rates generally are established using hospital specific cost and MA base year claims data.

Hospital outpatient services are reimbursed by MA under an APC methodology, subject to certain limitations. Total aggregate payment for outpatient hospital facility fee services cannot exceed the Medicare upper limit.

In addition to MA, the Department administers MinnesotaCare, the state's subsidized health insurance program for working Minnesotans without access to affordable health care coverage, which was enacted in 1992. The Department also administers various smaller waiver programs that provide additional assistance to certain targeted populations.

MinnesotaCare coverage is available to all who qualify – including singles and couples without children. To apply for MinnesotaCare insurance, a person must have no access to affordable health care coverage and must not have an annual income in excess of certain levels and, with respect to adults without children under the age of 21 living with them, must live in the state for at least six months before applying. Effective January 1, 2014, MinnesotaCare eligibility guidelines have been changed in order to enable more people to qualify by, for example, removing asset limitations. While MinnesotaCare is partly funded by federal funding and enrollee premiums, which are determined using a sliding-fee scale, based on family size and income, the majority of the program's funding is generated by a tax rate of 2% tax on gross revenues, of health care providers, including hospitals, subject to certain exceptions, and a 1% tax on nonprofit health plan premiums. All persons enrolled in MinnesotaCare receive their care through managed care health plans, which pay a monthly capitation payment for each MinnesotaCare enrollee. Reimbursement under MinnesotaCare is based on Medicaid rates and there can be no guarantees that such rates adequately cover the cost of care for MinnesotaCare beneficiaries.

Minnesota law, including the MinnesotaCare Act, sets forth various requirements to restrain the rate of growth in health care costs in Minnesota, and includes various reporting requirements applicable to participating health care providers. For example, certain providers, including hospitals, are required to provide an annual report to the Minnesota Commissioner of Health (the "Commissioner") with information related to major spending commitments, including offering new specialized services and any capital expenditures (in each case with a cost in excess of $1,000,000). The Commissioner does not have any approval or denial authority over such major spending commitments upon retrospective review, but is to use the information provided in an ongoing evaluation of statewide and regional progress towards overall health care cost containment. Providers who fail the retrospective

review, however, will risk the Commissioner's imposition of prospective review and approval of major capital expenditures. Minnesota law does not require reporting to the Commissioner for major spending commitments in the following situations: by research and teaching institutions for the purposes of conducting medical education or medical research supported or sponsored by a medical school or a federal or a foundation grant; for building maintenance; and for activities not directly related to the delivery of patient care services, including food service, laundry, and housekeeping. The reporting requirement also does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the Commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided. Minnesota law also requires hospitals to collect and provide certain patient specific information and descriptive and financial aggregate data. The effect on Allina Health of any future changes to those requirements cannot be predicted. Such matters, as well as more general governmental budgetary concerns, may in the future reduce payments made to providers under the MinnesotaCare program.

Audits and Withholds. Hospitals that participate in the Medicare and Medicaid programs are subject, from time to time, to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments with respect to reimbursements claimed under these programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments in certain circumstances. New billing rules and reporting requirements for which there is no clear guidance from CMS or state Medicaid agencies could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medicaid program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal health programs.

Authorized by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Medicare Integrity Program ("MIP") was established to deter fraud and abuse in the Medicare program. Funded separately from the general administrative contractor program, the MIP allows CMS to enter into contracts with outside entities and insure the "integrity" of the Medicare program. These entities include, but are not limited to, Medicare zone program integrity contractors ("ZPICs"), formerly known as program safeguard contractors. ZPICs are contracted by CMS to review claims and medical charts, both on a pre- and post-payment basis, conduct cost report audits and identify cases of suspected fraud. ZPICs have the authority to deny and recover payments as well as to refer cases to the Office of Inspector General (the "OIG"). ZPICs have the ability to compile claims data from multiple sources in order to analyze the complete claims histories of beneficiaries for inconsistencies.

The federal Medicaid Integrity Program was created by the Deficit Reduction Act of 2005 ("DRA") and appropriations for enforcement began in 2006. The Medicaid Integrity Program was the first federal program established to combat fraud and abuse in state Medicaid programs. Congress determined a federal program was necessary due to the substantial variations in state Medicaid enforcement efforts. The Medicaid Integrity Program's enforcement efforts support existing state Medicaid Fraud Control Units. Federal Medicaid Integrity Contractors ("MICs") are classified into Review MICs, Audit MICs and Education MICs. Review MICs perform review audits generally to determine trends and patterns of aberrant Medicaid billing practices through data mining. Audit MICs perform post-payment reviews of individual providers through desk or field audits. The Education MICs are responsible for developing and carrying out a variety of education activities to increase and improve Medicaid enforcement efforts by state government. Once a Medicaid overpayment is identified, the state has one year to recover, or attempt to recover, such overpayment before making an adjustment to refund the state's share of federal financial participation to CMS. If a state is unable to recover an overpayment due to fraud within one year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial proceeding, no adjustment can be made to the federal share prior to 30 days after the date on which the final judgment is made.

Medicare and Medicaid audits may result in reduced reimbursement or repayment obligations related to past alleged overpayments and may also delay Medicare or Medicaid payments to providers pending resolution of the appeals process. The ACA explicitly gives DHHS the authority to suspend Medicare and Medicaid payments to a provider or supplier during a pending investigation of fraud. The ACA also amended certain provisions of the FCA (as defined herein) to include retention of overpayments as a violation. It also added provisions respecting the timing of the obligation to identify, report and reimburse overpayments. See "BONDHOLDERS' RISKS – Regulatory Environment – False Claims Laws" below for additional information. The effect of these changes on existing programs and systems of Allina Health cannot be predicted.

In addition, contracts between hospitals and third-party payers often have contractual audit, setoff and withhold language that may cause substantial, retroactive adjustments. Such contractual adjustments also could have a material adverse effect on the financial condition and results of operations of Allina Health.

Disproportionate Share Payments. The Medicare and Medicaid programs each provide additional payment for hospitals that serve a disproportionate share of certain low-income patients. Some of Allina Health's facilities qualify as disproportionate share hospitals and receive disproportionate share payments. The ACA provides that beginning in federal fiscal year 2014, hospitals receiving supplemental Disproportionate Share ("DSH") payments from Medicare (i.e., those hospitals that care for a disproportionate share of low-income Medicare beneficiaries) were slated to have their DSH payments reduced significantly. This reduction potentially will be offset by new, additional payments based on the volume of uninsured and uncompensated care provided by each such hospital, and is anticipated to be offset by a higher proportion of covered patients as other provisions of the ACA go into effect. CMS finalized its rules for implementing the Medicare DSH payment adjustment in its fiscal year 2014 IPPS final rule, issued August 2, 2013.

On September 18, 2013, CMS issued a final rule confirming its methodology, which accounts for statewide reductions in uninsured and uncompensated care, for reducing Medicaid DSH allotments to each state. Under this final rule, the federal share of Medicaid DSH payments was reduced by $600 million in fiscal year 2015 and $600 million in fiscal year 2016 (and additional amounts through 2020). The Bipartisan Budget Act of 2013, however, restructured Medicaid DSH payment reductions by delaying Medicaid DSH payment reductions until fiscal year 2016, but increasing the overall level of reductions and extending cuts through fiscal year 2023. The Protecting Access to Medicare Act of 2014 further delayed the Medicaid DSH payment reductions until federal fiscal year 2017, but increased the level of such reductions and extended them through federal fiscal year 2024. MACRA further modified the planned reductions in Medicaid DSH payments by delaying fiscal year 2017 cuts until fiscal year 2018, restructuring the overall level of reductions, and extending cuts through fiscal year 2025. There can be no assurance that DSH funding will not be further decreased beyond projected reductions or eliminated entirely.

State Children's Health Insurance Program. The State Children's Health Insurance Program ("SCHIP") is a federally funded insurance program for children whose families are financially ineligible for Medicaid, but cannot afford commercial health insurance. CMS administers SCHIP, but each state creates its own program based upon minimum federal guidelines. Minnesota provides SCHIP benefits to uninsured children. While generally considered to be beneficial for both patients and providers by reducing the number of uninsured children, it is difficult to assess the fiscal impact of SCHIP on the payments to Allina Health. SCHIP insurance is provided through private health plans contracting with the state. Each state must periodically submit its SCHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for the program. Any such loss of funding or federal or state budget cuts to the program could have an adverse effect on provider revenues.

The ACA temporarily increased reimbursement for primary care visits for Medicaid enrolled individuals, funded 100% by the federal government in 2013 and 2014. The federal funding for the increase expired at the end of 2014. Under MACRA, federal funding for SCHIP was extended through September 30, 2017. When such funding expires there can be no assurances that funding for an increase will be reestablished at either a state or federal level, or that professional and /or facility reimbursement rates will not subsequently be reduced in efforts to manage costs.

Traditional Health Insurance. Many commercial insurance plans, including group plans, reimburse their customers or make direct payments to health care providers for charges at established rates. Generally, these plans pay at negotiated rates which are subject to various limitations and deductibles, depending on the plan. Patients carrying such coverage may be responsible to the provider for any deficiency between the commercial insurance proceeds and total billed charges, depending on the terms of the agreement between the provider and the plan. While this is a favorable method of reimbursement available to health care providers, there can be no assurance that this method of reimbursement will not decrease further in the future.

Health Plans and Managed Care. Most private health insurance coverage is provided by various types of "managed care" plans, including HMOs and PPOs. To control costs, managed care plans typically contract with

hospitals and other providers for discounted prices, review medical services for medical necessity, require members to pay copayments and deductibles, and channel patients to contracted providers of health care services. Medicare and Medicaid also purchase hospital care using managed care options. Payments to hospitals from managed care plans typically are lower than those received from traditional indemnity or commercial insurers.

For the fiscal years ended December 31, 2012, 2013 and 2014, Allina Health received approximately 57%, 57% and 55% of net patient service revenues from managed care plans. See APPENDIX A – "ALLINA HEALTH SYSTEM – FINANCIAL INFORMATION – Managed Care Relationships."

Many HMOs and PPOs currently pay providers on a negotiated fee-for-service basis or, for institutional care, on a fixed rate per day of care or per inpatient stay, which, in each case, usually is discounted from the typical charges for the care provided. As a result, the discounts offered to HMOs and PPOs may result in payment to a provider that is less than its actual cost. Additionally, the volume of patients directed to a provider may vary significantly from projections, and/or changes in the utilization may be dramatic and unexpected, thus jeopardizing the provider's ability to manage this component of revenue and cost.

Some HMOs employ a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" or otherwise directed to receive care at a particular hospital. A hospital may assume financial risk for the cost and scope of institutional care given. If payment is insufficient to meet a hospital's actual costs of care, or if utilization by such enrollees materially exceeds projections, the financial condition of a hospital could erode rapidly and significantly. In addition to this standard managed care risk sharing approach, private health insurance companies are increasingly adopting various additional risk sharing/cost containing measures, sometimes similar to those introduced by government payers. Providers may expect health care cost containment and its associated risk sharing to continue to increase in the coming years.

Commercial insurers in Minnesota are also adopting total cost of care strategies with providers in Minnesota and commercial insurers have also adopted pay for performance strategies with providers.

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

With implementation of the ACA, substantial numbers of employers may elect to discontinue employer-funded medical care for employees eligible for federal assistance in securing private insurance, and the employees could then chose health insurance under the health insurance exchanges. Individuals choosing their own coverage may become highly price sensitive, which could increase the number of enrollees in HMO plans and increase the use of capitation, making price negotiations with HMO and other insurance plans more difficult.

Failure to maintain contracts could have the effect of reducing Allina Health's market share and net patient services revenues. Conversely, participation may result in lower net income if participating hospitals are unable to adequately contain their costs. In part to reduce costs, health plans are increasingly implementing, and offering to purchasing employers, tiered provider networks, which involve classification of a plan's network providers into different tiers based on care quality and cost. With tiered benefit designs, plan enrollees are generally encouraged, through incentives or reductions in copayments or deductibles, to seek care from providers in the top tier. Classification of a hospital in a non-preferred or lower tier by a significant payer may result in a material loss of volume. The new demands of dominant health plans and other shifts in the managed care industry may also reduce patient volume and revenue. Thus, managed care plans pose one of the most significant business risks (and opportunities) that health care organizations face.

In addition, the current trend of consolidation in the health insurance industry is likely to increase the leverage of commercial insurers when negotiating rates with health care providers. Large health insurers that assume dominant positions in local markets threaten to increase health insurer concentration, reduce competition and decrease choice. If Allina Health were to terminate its agreement with any of the major managed care payers of Allina Health or not agree to terms proposed by such payers, it could have a significant material adverse impact on

the financial condition of Allina Health. See APPENDIX A – "ALLINA HEALTH SYSTEM – FINANCIAL INFORMATION – Managed Care Relationships" for the sources of revenues for Allina Health.

Increased Enforcement Affecting Research

In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also stepped up enforcement of laws and regulations governing the conduct of clinical trials at hospitals. DHHS elevated and strengthened its Office of Human Research Protection, one of the agencies with responsibility for monitoring federally funded research. The Food and Drug Administration ("FDA") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. The United States Department of Justice ("DOJ") may also become involved in enforcement actions relating to the use of federal funds or submission of information to federal agencies. There have been a number of recent government investigations and settlements involving hospital use of federal grant funding in connection with clinical trials and also a settlement involving the submission of claims to Medicare for services provided in a clinical trial. These agencies' enforcement powers range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs, and errors in billing of the Medicare or Medicaid programs for care provided to patients enrolled in clinical trials that is not eligible for Medicare reimbursement can subject Allina Health to sanctions as well as repayment obligations.

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

Health plans, Medicare and Medicaid programs, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and health care providers. The ACA shifts payments from paying for volume to paying for value, based on various health outcome measures. Published rankings such as "score cards," tiered hospital networks with higher co-payments and deductibles for non-emergent use of lower-ranked providers, "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals, the members of their medical staffs and other health care providers and to influence the behavior of consumers and providers such as Allina Health. Prevalent currently are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital or a health care provider negatively may adversely affect its reputation and financial condition.

Section 340B Drug Pricing Program

Hospitals that participate in the prescription drug discount program established under Section 340B of the federal Public Health Service Act (the "340B Program") are able to purchase certain outpatient drugs for their patients at reduced cost. The Health Resources and Services Administration within DHHS ("HRSA"), through the Office of Pharmacy Affairs, administers the 340B Program, and has announced that it intends to release proposed regulations governing many aspects of the 340B Program. HRSA issued a proposed rule on June 17, 2015, regarding 340B Program pricing and manufacturer civil monetary penalties. Additionally, on August 28, 2015, HRSA issued proposed 340B Drug Pricing Program Omnibus Guidance in the Federal Register, 80 Fed. Reg. 52300, which addresses key policy issues related to the 340B Program, including, but not limited to, eligibility and registration of hospitals and outpatient facilities, individuals eligible to receive 340B drugs, drugs eligible for purchase under the 340B Program, and manufacturer compliance. If adopted in its current form, the proposed guidance could, among other things, restrict the ability of Allina Health and certain of its subsidiaries to purchase drugs under the 340B Program. Such restrictions could have an adverse effect on Allina Health.

Regulatory Environment

"Fraud" and "False Claims." Health care "fraud and abuse" laws have been enacted at the federal and state levels to broadly regulate the provision of services to government program beneficiaries and the methods and requirements for submitting claims for services rendered to the beneficiaries. Under these laws, hospitals and other

health care providers can be penalized for a wide variety of conduct, including submitting claims for services that are not provided, billing in a manner that does not comply with government requirements or including inaccurate billing information, billing for services deemed to be medically unnecessary, or billings accompanied by an illegal inducement to utilize or refrain from utilizing a service or product.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud, including the exclusion of a hospital or other health care provider from participation in the Medicare and Medicaid programs, civil monetary penalties, and suspension of Medicare and Medicaid payments. Fraud and abuse cases may be prosecuted by one or more government entities and/or private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation.

Laws governing fraud and abuse may apply to hospitals and other health care providers, and to nearly all individuals and entities with which a hospital or other health care provider does business. Fraud investigations, settlements, prosecutions and related publicity can have a material adverse effect on hospitals and other health care providers. See "*Enforcement Activity*" below. Major elements of these often highly technical laws and regulations are generally summarized therein.

The ACA authorizes the Secretary of DHHS to exclude a provider's participation in Medicare and Medicaid for fraud, as well as suspend payments to a provider pending an investigation or prosecution of a credible allegation of fraud against the provider.

False Claims Laws. The federal False Claims Act ("FCA") makes it illegal to, among other activities, knowingly submit or present a false or fraudulent claim for payment or approval for payment for which the federal government provides, or reimburses, at least some portion of the requested money or property. Because the term "knowingly" is defined broadly under the law to include not only actual knowledge but also deliberate ignorance or reckless disregard of the facts, the FCA can be used to punish a wide range of conduct. FCA investigations and cases have become common in the health care field and may cover a range of activity from submission of intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Penalties under the FCA are severe and may include damages equal to three times the amount of the alleged false claims, as well as substantial civil monetary penalties. As a result, violation or alleged violation of the FCA frequently results in settlements that require multi-million dollar payments and costly corporate integrity agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," can share in the damages recovered by the government or recover independently if the government does not participate. Because qui tam lawsuits are kept under seal while the federal government evaluates whether the United States will join the lawsuit, it is impossible to determine at this time whether any such actions are pending against Allina Health and no assurances can be made that such actions will not be filed in the future. The FCA has become one of the government's primary weapons against health care fraud and suspected fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital and other health care providers.

Under the ACA, the FCA has been expanded to include overpayments that are discovered by a health care provider and are not promptly refunded to the applicable federal health care program, even if the claims relating to the overpayment were initially submitted without any knowledge that they were false. The ACA requires that providers return identified overpayments within 60 days of identification (of the date any corresponding cost report is due, if later and applicable) or the overpayment becomes an "obligation" under the FCA. There is great uncertainty in the industry as to when an overpayment is technically "identified" and the ability of a provider to determine the total amount of an overpayment and satisfy its repayment obligation within the 60 day time period. CMS has proposed regulations interpreting this requirement, but those regulations do not provide significant clarification as to the "identification" of an overpayment. It is unclear whether these regulations will become final. As of February 17, 2015, CMS announced a one-year delay in the timeline for the publication of a final rule concerning policies and procedures for reporting and returning overpayments, including the 60 day time period. This expansion of the FCA exposes hospitals and other health care providers to liability under the FCA for a considerably broader range of claims than in the past.

The DRA provides financial incentives to states that pass similar false claims statutes or amend existing false claims statutes that track the FCA more closely with regard to penalties and rewards to *qui tam* relators. A number of states, including Minnesota, have passed similar statutes.

Anti-Fraud and Abuse Provisions. The federal Medicare/Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act (collectively, the "Anti-Kickback Law") is a criminal statute that prohibits anyone from soliciting, receiving, offering or paying any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral of a patient (or to induce a referral) or the ordering or recommending of the purchase (or lease) of any item or service that is paid by any federal health care program. The Anti-Kickback Law applies to many common health care transactions between persons and entities with which a hospital does business, including hospital-physician joint ventures, services agreements, director agreements, physician recruitment agreements, physician office leases, and other transactions. Allina Health participates in such arrangements in the ordinary course of business. The ACA amended the Anti-Kickback Law to provide explicitly that a claim that includes items or services resulting from a violation of the Anti-Kickback Law constitutes a false or fraudulent claim for purposes of the FCA. Another amendment provides that an Anti-Kickback Law violation may be established without showing that an individual knew of the statute's proscriptions or acted with specific intent to violate the Anti-Kickback Law, but only that the conduct was generally unlawful.

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

Violations or alleged violations of the Anti-Kickback Law often result in settlements that require multi-million dollar payments and onerous corporate integrity agreements. The Anti-Kickback Law can be prosecuted either criminally or civilly. A criminal violation may be prosecuted as a felony, subject to a fine of up to $25,000 for each criminal act (which may be each item or each bill sent to a federal program) and/or imprisonment, either of which would have a significant detrimental effect on the financial stability of most hospitals. In addition, civil monetary penalties of $50,000 per violation of the Anti-Kickback Law and an "assessment" of three times the amount claimed may be imposed. Violators can also be excluded from federal healthcare programs, including Medicare and Medicaid programs. Increasingly, the federal government and qui tam relators are prosecuting violations of the Anti-Kickback Law under the FCA. See the discussion under the subheading "*False Claims Laws*" above. The IRS has taken the position that hospitals that are in violation of the Anti-Kickback Law may also be subject to revocation of their tax-exempt status.

Chapter 62J of the Minnesota Statutes, regarding health care cost containment, contains a conflict of interest provision that, in essence, applies the Anti-Kickback Law to the provision of health care to all patients, not just those covered under federal health care programs. The Commissioner has the authority to adopt regulations implementing the conflict of interest provision, but has not yet done so. Until the Commissioner adopts such regulations, the Anti-Kickback Law is deemed to apply to all health care services and providers in Minnesota, regardless of the source of payment. The regulations, when adopted, could be broader and more encompassing than the Anti-Kickback Law and could prohibit certain arrangements permitted under the law and its enacting regulations. Fines may be assessed against providers for violations of these restrictions.

Management of Allina Health believes that the respective arrangements of Allina Health with referral sources are in compliance with the Anti-Kickback Law. However, because of the breadth of the Anti-Kickback Law and the narrowness of the safe harbor regulations, there can be no assurances that in the future Allina Health will not be found to have violated the Anti-Kickback Law and, if so, whether any sanction imposed would have a material adverse effect upon the operations and financial condition of Allina Health or the continued status of Allina Health as an organization described in Section 501(c)(3) of the Code.

Liability Under State "Fraud" and "False Claims" Laws. Hospital providers in Minnesota are also subject to a variety of state laws related to false claims (similar to the FCA or that are generally applicable or even program-specific false claims laws), anti-kickback (similar to the federal Anti-Kickback Law or that are generally applicable anti-kickback, conflict of interest or fraud laws), and physician referral (similar to Stark). The DRA provides financial incentives to states that pass similar false claims statutes or amend existing false claims statutes that track the FCA more closely with regard to penalties and rewards to qui tam relators. A number of states, including Minnesota, have passed similar statutes. A violation of these laws could have a material adverse impact on a hospital for the same reasons as the federal statutes. See discussion under the subheadings "'Fraud' and 'False Claims,'" "False Claims Law" and "Anti-Fraud and Abuse Provisions" above and "Physician Self-Referral Prohibition" below.

Minnesota has several publicly funded health care programs, including MA, several population-specific waiver programs, and MinnesotaCare. Together these are referred to as the "Minnesota Health Care Programs." See "Patient Service Revenues – The Medicaid Program – Minnesota Reimbursement Programs" for additional information regarding the Minnesota Health Care Programs.

Within the Department is a unit known as the Surveillance and Integrity Review Section ("SIRS"). SIRS is responsible for identifying and investigating suspected fraud, theft and abuse, and enforces Department rules. SIRS is authorized to seek monetary recovery, impose administrative sanctions and seek civil or criminal action through the office of the Attorney General. Possible sanctions for health care fraud and abuse include suspension or termination of a provider's ability to participate in Minnesota Health Care Programs.

The Department defines "abuse" in its Minnesota Health Care Programs Provider Manual as a pattern of practice that is inconsistent with sound fiscal, business or health service practices and that results in unnecessary costs to Minnesota Health Care Programs or in reimbursement for services not medically necessary. The same manual defines "fraud" to include acts that constitute a crime against any program or attempts or conspiracies to commit those crimes. Examples of fraud include (1) acts that violate the federal Anti-Kickback Law, (2) making a false statement, claim or representation to a program the person knows or should reasonably know is false and (3) theft, perjury, forgery, aggravated forgery, MA fraud or financial transaction card fraud.

Allina Health's management believes that Allina Health's operations presently are in material compliance with all state fraud and abuse laws. Nevertheless, in view of the broad scope and complexity of the laws and the limited case law interpreting them, there can be no assurance that a violation of the fraud and abuse laws will be not investigated or found, and if found, that fines and penalties will not be imposed that could have a material adverse effect on the operations or financial condition of Allina Health.

Physician Self-Referral Prohibition. The federal "Stark Law" prohibits the referral by a physician of Medicare patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and radiation and other imaging services) to entities with which the referring physician has a financial relationship, unless the relationship fits within a stated exception. It also prohibits a hospital furnishing the designated services from billing for services performed pursuant to a prohibited referral. The government does not need to prove that the entity knew that the referral was prohibited to establish a Stark Law violation.

The types of financial arrangements between a physician (or a physician's immediate family member) and an entity that trigger the self-referral prohibitions of the Stark Law are broad and include ownership and investment interests and compensation arrangements as well as certain disclosure obligations. Most providers of designated health services with physician relationships have some exposure to liability under the Stark Law for payments to physicians. There are, however, exceptions for certain specified arrangements. If certain substantive and technical requirements of an applicable exception are not satisfied, however, many ordinary business practices and economically desirable arrangements between hospitals and physicians may constitute improper "financial relationships" within the meaning of the Stark Law, thus triggering the prohibition on referrals and billing. Regulations promulgated under the Stark Law are subject to frequent amendment. Such amendments could require Allina Health to amend or terminate certain arrangements with physicians to comply with new regulatory requirements.

Medicare may deny payment for all services related to a prohibited referral and a hospital that has billed for prohibited services is obligated to notify and refund the amounts collected from the Medicare program. For example, if an office lease between a hospital and a large group of heart surgeons is found to violate the Stark Law, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed at the hospital by all of the physicians in the group for the duration of the lease, which could potentially be a significant amount. As a result, even relatively minor, technical violations of the law may trigger substantial refund obligations. Sanctions for violation of the Stark Law include denial of payment for the services provided in violation of the prohibition, refunds of amounts improperly collected, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law's prohibition, and/or exclusion from participation in the federal health care programs. Potential repayments to CMS, settlements, fines or exclusion for a Stark Law violation or alleged violation could have a material adverse impact on a hospital and other health care providers. Increasingly, the federal government and qui tam relators are prosecuting violations of the Stark Law under the FCA, based on the argument that claims resulting from an illegal referral arrangement are also false claims for FCA purposes. See the discussion under the subheading "False Claims Laws" above.

CMS has established a voluntary self-disclosure program under which hospitals and other entities may report Stark Law violations and seek a reduction in potential refund obligations. However, the program is relatively new and therefore it is difficult to determine at this point in time whether it will provide significant monetary relief to hospitals that discover inadvertent Stark Law violations. The limited publicly available information with respect to the self-disclosure program suggests that most voluntary self-disclosure submissions remain under consideration by CMS for an extended period of time, and that it is difficult to predict how CMS will react to any specific voluntary self-disclosure. Allina Health has made and may make future self-disclosures under this program as appropriate from time to time as part of its ongoing effort to comply with the Stark Law. Any submission pursuant to the self-disclosure program does not waive or limit the ability of the OIG or DOJ to seek or prosecute for violations of the Anti-Kickback Law or impose civil monetary penalties.

Although the Stark Law only applies to Medicare, a number of states (including Minnesota) have passed similar statutes pursuant to which similar types of prohibitions are made applicable to all other health plans or third-party payers. Minnesota law provides that the Commissioner on Health may audit the referral patterns of providers that qualify for Stark Law exceptions and that the Commissioner shall report to the Minnesota Legislature any audit results that reveal a pattern of referrals by a provider for the furnishing of health services to any entity with which the provider has a direct or indirect financial relationship. This audit authority extends to all health care services rather than just Stark Law designated health services. In 2004, the Minnesota Legislature enacted Minnesota Statute Section 144.6521, which requires patients be informed in writing prior to receiving a referral to a hospital, outpatient surgical center, diagnostic imaging facility or any affiliates thereof, if the referring provider has an economic interest or an employment or contractual arrangement with such facility. In addition, a written notice of the relationship must be posted in the patient reception area, waiting room, or other conspicuous public location within the provider's facility.

Management of Allina Health believes that Allina Health is presently in material compliance with the physician self-referral prohibitions and the Stark Law. However, in view of the broad scope and ambiguity of the self-referral prohibitions and the Stark Law regulations, the narrowness of the exceptions and the lack of case law or regulations interpreting the self-referral prohibitions, there can be no assurance that no additional violations of the self-referral prohibitions will be found in the future, or that any sanctions imposed will not have a material adverse effect on the operation or the financial condition or results of operations of Allina Health.

HIPAA; Privacy Requirements. HIPAA adds additional criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds or other assets of a health care benefit program. A health care provider convicted of health care fraud could be excluded from Medicare.

HIPAA also addresses the confidentiality of individuals' health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient. HIPAA's confidentiality provisions extend not only to patient

medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication, operational, accounting and billing restrictions.

DHHS has promulgated privacy regulations under HIPAA that protect patient medical records and other personal health information maintained by health care providers, hospitals, health plans, health insurers and health care clearinghouses (the "Privacy Regulations"). Management of Allina Health believes that its operations and information systems comply with the Privacy Regulations. Security regulations have also been promulgated under HIPAA (the "Security Regulations"). Additionally, DHHS has promulgated regulations to standardize the electronic transfer of information pursuant to certain enumerated transactions (the "Code Set Transactions"). Management of Allina Health believes that it is in substantial compliance with the Security Regulations and the Code Set Transactions. However, as national and worldwide security breaches show, no organization is immune from any number of intentional or unintentional attacks or breaches of information security

HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. For more information, see "BONDHOLDERS' RISKS – Regulatory Environment – The HITECH Act" below.

ARRA includes broad, sweeping changes to HIPAA through the HITECH Act (as defined below). For more information, see "The HITECH Act" below.

The Office for Civil Rights ("OCR") is the administrative office that is tasked with enforcing HIPAA. OCR has stated that it has now moved from education to enforcement in its implementation of the law. Recent settlements of HIPAA violations for breaches involving lost data have reached the millions of dollars. Any breach of HIPAA, regardless of intent or scope, may result in penalties or settlement amounts that are material to a covered health care provider.

Additionally, other federal laws and state laws address the confidentiality of individuals' health information. The Minnesota Health Records Act imposes strict requirements related to release or disclosure of medical records, patients' access to their records and maintaining the privacy and security of records, with particular emphasis on certain types of information (e.g., information that relates to mental health). Potential penalties for violations of the Minnesota Health Records Act include disciplinary actions by the applicable licensing board and compensatory damages to patients affected by the violation.

Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of relevant federal and state statutes and regulations or authorized by the patient. These restrictions add costs and create potentially unanticipated sources of legal liability.

Implementation of Revised ICD-10. United States health care providers and payers (including Medicare and Medicaid) currently operate under the International Classification of Diseases ("ICD") Number 9 to report and bill for care. Revised ICD-10 is a new system for medical diagnosis and inpatient and outpatient procedure coding and was scheduled to go into effect in the United States on October 1, 2013, for every person and organization covered by HIPAA. Australia and Canada have already implemented ICD-10 and their experience shows that providers and payers in the United States need to invest significantly in software, education and training for this implementation. In August 2012, DHHS issued a rule delaying this compliance deadline until October, 1 2014. On March 31, 2014, Congress passed legislation delaying the ICD-10 implementation deadline to October 1, 2015.

ICD-10 provides a common approach to the classification of diseases and other health problems, allowing the United States to align with other nations to better share medical information, diagnosis, and treatment codes. ICD-10 is not without risk as staff will need to be retrained, processes redesigned, and computer applications modified as the current available codes and digit size will dramatically increase. Additionally, there is a potential for temporary coding and payment backlog, as well as potential increases in claims errors. There is a potential for revenue stream disruption for health care organizations and the magnitude of the transition within the industry may add pressure to health care organizations cash flows. Health care organizations will be dependent on outside software vendors, clearinghouses and third-party billing services to develop products and services to allow timely, full and successful implementation of ICD-10. Delays in the required implementation may occur if such ICD-10 products and services are not available to health care organizations from these outside sources well in advance of the

implementation deadline to allow for adequate testing and installation. The continued delay of ICD-10 implementation is likely to result in increased training and related implementation costs for Allina Health. Further, it remains unclear whether continued delay in ICD-10 implementation will ultimately resolve potential implementation issues.

Submission and processing of claims data under ICD-10 will be more complex; it is likely that some claims may be rejected or delayed due to faulty transmission or receipt of data. Delayed payments would result in lower cash flow to providers. Management of Allina Health is working on implementation of Revised ICD-10 but cannot in these early stages predict the impact of these changes on the finances and operations of Allina Health.

Security Breaches and Unauthorized Releases of Personal Information. Federal, state and local authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently damage a health care provider's reputation and materially adversely affect business operations.

The HITECH Act. Provisions in the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, made dramatic changes to HIPAA. On January 25, 2013, DHHS issued comprehensive modifications to the existing HIPAA regulations to implement the requirements of the HITECH Act, commonly known as the "HIPAA Omnibus Rule." The HIPAA Omnibus Rule became effective on March 26, 2013, and covered entities were required to be in compliance by September 23, 2013 (though certain requirements have a longer timeframe). Key aspects of the HIPAA Omnibus Rule include, but are not limited to: (i) a new standard for what constitutes a breach of protected health information, (ii) establishing four levels of culpability with respect to civil monetary penalties assessed for HIPAA violations, (iii) direct liability of business associates for certain violations of HIPAA, (iv) modifications to the rules governing research, (v) stricter requirements regarding non-exempt marketing practices, (vi) modification and re-distribution of notices of privacy practices, and (vii) stricter requirements regarding the protection of genetic information. The obligations imposed under the HIPAA Omnibus Rule could have a material adverse effect on the financial condition of health care organizations.

The HITECH Act revises the civil monetary penalties associated with violations of HIPAA as well as provides state attorneys general with authority to enforce the HIPAA Privacy Regulations and Security Regulations. The revised civil monetary penalty provisions establish a tiered system, ranging from a minimum of $100 per violation for an unknowing violation to $1,000 per violation for a violation due to reasonable cause, but not willful neglect. For a violation due to willful neglect, the penalty is between $10,000 and $50,000 per violation, depending on whether the violation was corrected within 30 days of the date the violator knew or should have known of the violation. Maximum penalties may reach $1,500,000 for identical violations. The new levels of civil monetary penalties apply immediately for unknowing violations or violations due to reasonable cause.

Criminal penalties will be enforced against persons who obtain or disclose personal health information without authorization. DHHS is also beginning to perform periodic audits of health care providers and group health plans to ensure that required policies under the HITECH Act are in place. Finally, while there is currently no private cause of action for violations of HIPAA or the HITECH Act, individuals harmed by violations will be able to recover a percentage of monetary penalties or a monetary settlement based upon methods to be established by DHHS.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health record ("EHR") technology. The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals for

demonstrating meaningful use of certified EHR technology. Health care providers demonstrate their meaningful use of EHR technology by meeting objectives specified by CMS for using health information technology and by reporting on specified clinical quality measures. Beginning in fiscal year 2015, hospitals that have not satisfied the performance and reporting criteria for demonstrating meaningful use will have their Medicare payments significantly reduced. Management of Allina Health does not anticipate that compliance with the HITECH Act will have a material adverse effect on the operations of Allina Health

Additionally, beginning in 2014, the federal government began auditing hospitals' and providers' records related to their attestation of being "meaningful users" in order to obtain the incentive payments. A hospital or provider that fails the audit will have an opportunity to appeal. Ultimately, hospitals or providers that fail on appeal will have to repay any incentive payments they received through these programs. See APPENDIX A – "ALLINA HEALTH SYSTEM – MANAGEMENT" for information about information technology of Allina Health.

Cybersecurity Risks. Despite the implementation of network security measures by Allina Health, its information technology systems may be vulnerable to breaches, hacker attacks, computer viruses, physical or electronic break-ins and other similar events or issues. Such events or issues could lead to the inadvertent disclosure of protected health information or other confidential information or could have an adverse effect on the ability of Allina Health to provide health care services. One recent highly publicized cyber-attack in the health care sector was on the health insurer Anthem, Inc.

Civil Monetary Penalties Law. The federal Civil Monetary Penalties Law ("CMPA") provides for administrative sanctions against health care providers for a broad range of billing and other abuses. A health care provider is liable under the CMPA if it, among other activities, knowingly presents, or causes to be presented, an improper claim for reimbursement under Medicare, Medicaid and other federal health care programs. A hospital that participates in arrangements known as "gainsharing" by paying a physician to limit or reduce services to Medicare fee-for-service beneficiaries also could be subject to CMPA penalties if the arrangements are not structured appropriately. A health care provider that provides benefits to Medicare or Medicaid beneficiaries that such provider knows or should know are likely to influence the beneficiaries to choose the provider for their care also could be subject to CMPA penalties.

The CMPA authorizes the imposition of a civil money penalty and treble damages. The ACA amended the CMPA laws to establish various new grounds for exclusion and civil monetary penalties, as well as increased penalty thresholds for existing civil monetary penalties. The Secretary of HHS, acting through the OIG, also has both mandatory and permissive authority to exclude individuals and entities from participation in federal health care programs pursuant to this statute. Health care providers may be found liable under the CMPA even when they did not have actual knowledge of the impropriety of their action. Knowingly undertaking the action is sufficient. Ignorance of the Medicare regulations is no defense. The imposition of civil money penalties on a health care provider could have a material adverse impact on the provider's financial condition.

Exclusions from Medicare or Medicaid Participation. The government may exclude a hospital or other health care provider from Medicare and Medicaid program participation if it is convicted of a criminal offense relating to the delivery of any item or service reimbursed under Medicare or a state health care program, any criminal offense relating to patient neglect or abuse in connection with the delivery of health care, felony fraud against any federal, state or locally financed health care program or a felony offense relating to the illegal manufacture, distribution, prescription or dispensing of a controlled substance. The government also may exclude individuals or entities under certain other circumstances, such as an unrelated conviction of fraud or other financial misconduct relating either to the delivery of health care in general or to participation in a federal, state or local government program. Exclusion from the Medicare and Medicaid programs means that a hospital or other health care provider would be terminated from participation and no program payments can be made. Any hospital exclusion could be a materially adverse event, even within a large hospital system. In addition, exclusion of hospital employees may be another source of potential liability for hospitals or health systems.

Compliance with Conditions of Participation. CMS, in its role of monitoring participating providers' compliance with Conditions of Participation in the Medicare program, may determine that a provider is not in compliance with its Conditions of Participation. In that event, a notice of termination of participation in Medicare may be issued or other sanctions potentially could be imposed.

Enforcement Activity. Enforcement activity against hospitals and health care providers has increased and enforcement authorities have adopted aggressive approaches. Hospitals and other health care providers are frequently subject to audits, investigations or other enforcement actions regarding the health care fraud laws mentioned above. In addition, enforcement agencies increasingly pursue sanctions for violations of health care fraud and abuse laws through civil administrative actions. Administrative regulations may require less proof of a violation than do criminal laws and, thus, health care providers may have a higher risk of imposition of monetary penalties as a result of administrative enforcement actions.

Enforcement actions may pertain to not only deliberate violations, but also frequently relate to violations resulting from actions of which management is unaware, from mistakes or from circumstances where the individual participants do not know that their conduct is in violation of law. Enforcement actions may extend to conduct that occurred in the past. The government may seek a wide array of penalties, including withholding essential payments under the Medicare or Medicaid programs or exclusion from those programs.

Enforcement authorities are often in a position to compel settlements by providers charged with or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and/or similar payments and/or by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed, and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, a hospital or other health care provider could experience materially adverse settlement costs, as well as materially adverse costs associated with implementation of any settlement agreement. Prolonged and publicized investigations could be damaging to the reputation and business of a hospital or other health care provider, regardless of outcome.

Certain acts or transactions may result in violation or alleged violation of a number of the federal health care fraud laws described above and, therefore, penalties or settlement amounts can be compounded. Generally these risks are not covered by insurance. Enforcement actions may involve multiple hospitals or health care providers in a health system, as the government often extends enforcement actions regarding health care fraud to other hospitals or health care providers in the same organization. Therefore, health care fraud related risks identified as being materially adverse as to a hospital or other health care provider could have materially adverse consequences to a health system taken as a whole.

EMTALA. The federal Emergency Medical Treatment and Active Labor Act ("EMTALA") is a federal civil statute that requires hospitals to conduct a medical screening for emergency conditions and to stabilize a patient's emergency medical condition before releasing, discharging or transferring the patient. A hospital that violates EMTALA is subject to civil penalties of up to $50,000 per offense and exclusion from Medicare and Medicaid programs. In addition, a hospital may be liable for any claim by an individual who has suffered harm as a result of a violation of EMTALA. Allina Health cannot predict the future impact of providing care required by EMTALA.

Licensing, Surveys, and Accreditation. Health facilities are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and appropriate accrediting organizations. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses, certifications or accreditations could reduce hospital utilization or revenues, or a hospital's ability to operate all or a portion of its facilities.

Management of Allina Health currently anticipates no difficulty renewing or continuing currently held licenses, certifications or accreditations. Nevertheless, actions in any of these areas could result in the loss of utilization or revenues, or Allina Health's ability to operate all or a portion of its facilities, and, consequently, could adversely affect Allina Health's ability to make payments in amounts sufficient to make the payments pursuant to the Bond Indenture or by Allina Health and any future Members of the Obligated Group to make payments pursuant to the Series 2015 Obligation and, consequently, payment of debt service on the Bonds.

Environmental Laws and Regulations. Hospitals and other health facilities are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. These include but

are not limited to: air and water quality control requirements, waste management requirements, specific regulatory requirements applicable to asbestos and radioactive substances, requirements for providing notice to employees and members of the public about hazardous materials handled by or located at a hospital and requirements for training employees in the proper handling and management of hazardous materials and wastes.

Hospitals and other health facilities may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospital operations are particularly susceptible to the practical, financial and legal risks associated with the environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and/or increase their cost, may result in legal liability, damages, injunctions or fines, may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions, and may not be covered by insurance.

Management of Allina Health is not aware of any pending or threatened claim, investigation or enforcement action regarding environmental matters which management believes will have a material adverse impact on Allina Health.

Hospital Construction Moratorium. With some limited exceptions, Section 144.551 of the Minnesota Statutes, prohibits the increase or redistribution of hospital beds within the state or the establishment of a new hospital. Any other increase or redistribution of hospital beds or establishment of a new hospital in Minnesota requires legislative approval. The state also imposes moratoria on certain other hospital construction, for example, new radiation therapy facilities. Such prohibitions may interfere with providers' ability to engage in strategic and capital planning and expansion.

Joint Ventures. The OIG has expressed its concern in various advisory bulletins that many types of joint venture arrangements involving hospitals may implicate the Anti-Kickback Law, since the parties to joint ventures are typically in a position to refer patients of federal health care programs. In its 1989 Special Fraud Alert, the OIG raised concern about certain physician joint ventures where the intent is not to raise investment capital to start a business but rather to lock up a stream of referrals from the physician investors and compensate the investors indirectly for the referrals. The OIG listed various features of suspect joint ventures, but noted that its list was not exhaustive. These features include: (i) whether investors are chosen because they are in a position to make referrals; (ii) whether physicians with more potential referrals are given larger investment interests; (iii) whether referrals are tracked and referral sources shared with investing physicians; (iv) whether the overall structure is a "shell" (i.e., one of the parties is an ongoing entity already engaged in a particular line of business); and (v) whether investors are required to invest a disproportionately small amount or are paid extraordinary returns in comparison with their risk.

In April 2003, the OIG issued a Special Advisory Bulletin, which indicated that "contractual joint ventures" (where a provider expands into a new line of business by contracting with an entity that already provides the items or services) may violate the Anti-Kickback Law and that expressed skepticism that existing statutory or regulatory safe-harbors would protect suspect contractual joint ventures. In January 2005, the OIG published its Supplemental Compliance Program Guidance for Hospitals and reiterated its concerns regarding joint ventures entered into by hospitals.

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

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

Any evaluation of compliance with the Anti-Kickback Law or tax laws governing Section 501(c)(3) organizations depends on the totality of the facts and circumstances, while the Stark Law requires strict compliance

with an exception if the prohibition is triggered. While management of Allina Health believes that the joint venture arrangements to which Allina Health is a party are in material compliance with the Anti-Kickback Law, OIG pronouncements, the tax laws governing Section 501(c)(3) organizations and the Stark Law, there can be no assurance that regulatory authorities will not take a contrary position or that such transactions will not be found to have violated these laws and related regulations. Any determination that Allina Health is not in compliance with these laws and related regulations could have a material adverse effect on the future financial condition of Allina Health.

Implantable Cardioverter Defibrillators Investigations. In 2010, the DOJ served subpoenas on and issued letters to a number of hospitals and health systems across the country as part of an investigation into whether hospitals billed Medicare for implantable cardioverter defibrillators ("ICD") for patients whose conditions did not satisfy coverage criteria set forth in CMS National Coverage Determination. Allina Health was reviewed by the DOJ in connection with this matter and entered into a settlement agreement with the DOJ in May 2014.

Possible Acquisitions and Other Strategic Initiatives

From time to time, management of Allina Health considers possible acquisitions or other investments in related assets, including other hospitals, as well as other strategic initiatives that may involve the investment of substantial capital resources or other material financial commitments. Such transactions present a variety of risks, including the risk that any such transactions may be perceived negatively by the investor community and the risks that any financial investments or commitments could result in deterioration in the financial condition or results of operations of Allina Health and its consolidated subsidiaries. There is also the risk that any such acquisitions or transactions could require management of Allina Health or its subsidiaries to dedicate a substantial amount of its time to the process of completing such transactions or, once completed, to the integration of such assets or new entities into Allina Health or its subsidiaries. As part of its ongoing planning and property management functions, the management of Allina Health reviews the use, compatibility and business viability of many of its operations, and from time to time Allina Health may pursue changes in the use of, or disposition of, its facilities. In addition to relationships with other hospitals and physicians, Allina Health may consider investments, ventures, affiliations, development and acquisition of other health care-related entities. These may include home health care, long-term care entities or operations, infusion providers, pharmaceutical providers, and other health care enterprises that support the overall operations of Allina Health. In addition, Allina Health may pursue transactions with health insurers, HMOs, PPOs, third-party administrators and other health insurance-related businesses. Because of the integration occurring throughout the health care field, management will consider these arrangements if there is a perceived strategic or operational benefit for Allina Health. Any initiative may involve significant capital commitments and/or capital or operating risk (including, potentially, insurance risk) in a business in which Allina Health may have less expertise than in hospital operations. There can be no assurance that these projects, if pursued, will not lead to material adverse consequences to Allina Health.

Fundraising

In recent years, Allina Health has received substantial gifts that it uses for a variety of purposes. Since 2012, the total of gifts, grants and bequests exceeded $90.7 million for Allina Health. Charitable contributions may be affected by a variety of factors, including general economic conditions, tax laws, competing needs for charitable funds and reputation of Allina Health. Charitable contributions are an important component enabling Allina Health to pursue its mission, including teaching, research, and providing charitable care. In the absence of such contributions, certain programs would likely be curtailed, or alternatively, funds would be transferred from other important priorities. Such steps could adversely affect programs and reputation of Allina Health, and the ability of Allina Health to make the payments pursuant to the Bond Indenture or by Allina Health and any future Members of the Obligated Group to make payments pursuant to the Series 2015 Obligation and, consequently, payment of debt service on the Bonds.

Research Matters

Allina Health regularly receives public and private contributions and/or payments in the form of grants, contracted drug studies and private donations related to the conduct of medical research and development. Conducting such research and development is an important component of certain of Allina Health's programs, both

financially and in terms of their respective missions. Obtaining such financing is competitive, and retaining physicians and scientists to maintain a healthy research program depends in part upon maintaining facilities and support for such research. In addition, the development of new products through research has in the past resulted in additional revenues to Allina Health. There is no assurance that the availability of research funding will continue or that Allina Health will be able to attract such funding. A decrease of such funding or such research programs could have an adverse effect upon Allina Health. Further, there is no assurance that Allina Health's involvement in the creation of new medical technologies will generate future income.

Conducting research involving human subjects entails risk that may be more pronounced than the risk associated with, for example, medical malpractice. Research subjects may often have an adverse response to therapy administered as part of research protocols, researchers may make mistakes, and new technology may have unintended side effects. In research contexts, adverse effects of research have the potential to generate substantial adverse publicity, and the potential conflict of interest that a researcher may have could increase liability risk and worsen the public's reaction to any bad outcomes. The government has also subjected certain research institutions to increased scrutiny related to research mishaps or perceived conflicts of interest.

In addition, the relationships between the sponsors of research and physicians or hospitals may also implicate the Anti-Kickback Law or the FCA. Should there be a finding of improper conduct on the part of Allina Health, it is possible that the government could suspend research operations by such member, or terminate such member's ability to participate in government-sponsored programs.

Business Relationships and Other Business Matters

Integrated Delivery Systems. Hospitals and health care systems often own, control or have affiliations with relatively large physician groups. Generally, the sponsoring hospital or health care system is the primary capital and funding source for such alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits. These types of alliances are generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care, to increase physician availability to the community and/or to enhance the managed care capability of the affiliated hospitals and physicians. These goals may not be achieved, however, and an unsuccessful alliance may be costly and counterproductive to all of the above-stated goals. The ACA authorizes several alternative payment programs for Medicare that promote, reward or necessitate integration among hospitals, physicians and other providers.

Whether these programs will achieve their objectives and be expanded or mandated as conditions of Medicare participation cannot be predicted. However, Congress and CMS have clearly emphasized continuing the trend away from the fee-for-service reimbursement model, which began in the 1980s with the introduction of the prospective payment system for inpatient care, and toward an episode-based payment model that rewards use of evidence-based protocols, quality and satisfaction in patient outcomes, efficiency in using resources, and the ability to measure and report clinical performance. This shift is likely to favor integrated delivery systems, which may be better able than standalone providers to realize efficiencies, coordinate services across the continuum of patient care, track performance and monitor and control patient outcomes. Changes to the reimbursement methods and payment requirements of Medicare, which is the dominant purchaser of medical services, are likely to prompt equivalent changes in the commercial sector, because commercial payers frequently follow Medicare's lead in adopting payment policies.

While payment trends may stimulate the growth of integrated delivery systems, these systems carry with them the potential for legal or regulatory risks. Many of the risks discussed in "BONDHOLDERS' RISKS – Regulatory Environment" herein, may be heightened in an integrated delivery system. The foregoing laws were not designed to accommodate coordinated action among hospitals, physicians and other health care providers to set standards, reduce costs and share savings, among other things. In October 2011, CMS, the Federal Trade Commission and the DOJ issued guidance regarding waivers and safe harbors to enable providers to participate in the Medicare Shared Savings Program ("MSSP") (see "Accountable Care Organization" below). Although CMS and the agencies that enforce these laws are expected to institute new regulatory exceptions, safe harbors or waivers that will enable providers to participate in payment reform programs, there can be no assurance that such regulations will be forthcoming or that any regulations or guidance issued will sufficiently clarify the scope of permissible activity. State law prohibitions, such as the bar on the corporate practice of medicine, or state law requirements,

such as insurance laws regarding licensure and minimum financial reserve holdings of risk-bearing organizations, may also introduce complexity, risk and additional costs in organizing and operating integrated delivery systems. Tax-exempt hospitals also face the risk in affiliating with for-profit entities that the IRS will determine that compensation practices or business arrangements result in private benefit or private use or generate unrelated business income for the hospitals. In addition, integrated delivery systems present business challenges and risks. Inability to attract or retain participating physicians may negatively affect managed care, contracting and utilization. The technological and administrative infrastructure necessary both to develop and operate integrated delivery systems and to implement new payment arrangements in response to changes in Medicare and other payer reimbursement is costly. Hospitals may not achieve savings sufficient to offset the substantial costs of creating and maintaining this infrastructure.

The ability of hospitals or health care systems to conduct integrated physician operations may be altered or eliminated in the future by legal or regulatory interpretation or changes, or by health care fraud enforcement. In addition, participating physicians may seek their independence for a variety of reasons, thus putting a hospital or health care system's investment at risk, and potentially reducing its managed care leverage and/or overall utilization.

Integrated delivery systems will require new infrastructures, including the appropriate mix of physician specialties, new administrative skills, close relationships between physicians and hospitals, insurance risk management, and new relationships between patients and providers. Provider organizations may be unsuccessful in assembling successful integrated networks, may not achieve savings sufficient to offset the substantial costs of creating and maintaining the necessary infrastructures to support such developments, could incur losses from assuming increased risk and could incur damage to reputations. Some health care organizations that traditionally operated hospitals may, directly or in partnership, take on actual insurance risk, market various health coverage products and access patients by way of new and presently unknown channels. Such new endeavors could adversely affect the financial and operating condition or reputation of an organization.

Physician Financial Relationships. In addition to the physician integration relationships referred to above, hospitals and health systems frequently have various additional business and financial relationships with physicians and physician groups. These are in addition to hospital physician contracts for individual services performed by physicians in hospitals. They potentially include: joint ventures to provide a variety of outpatient services; recruiting arrangements with individual physicians and/or physician groups; loans to physicians; medical office leases; equipment leases from or to physicians; and various forms of physician practice support or assistance. These and other financial relationships with physicians (including hospital physician contracts for individual services) may involve financial and legal compliance risks for the hospitals and health systems involved. From a compliance standpoint, these types of financial relationships may raise federal and state "anti-kickback" and federal "Stark" issues (see "BONDHOLDERS' RISKS – Regulatory Environment," including "– Regulatory Environment – Joint Ventures" above), tax exemption issues (see "BONDHOLDERS' RISKS – Tax-Exempt Status and Other Tax Exemption; Tax Audits," below), as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals.

Bundled Payment Programs. The ACA established a Medicare bundled payment pilot program, under which Medicare will make a single payment for an episode of care, such as heart bypass surgery, covering some combination of hospital, physician and post-hospital care for the episode. Private insurers are also developing bundled payment programs. While bundled payments offer opportunities to provide better coordinated care and to save costs, they also entail financial risk if the episode is not well managed.

Accountable Care Organization. The ACA establishes the MSSP that seeks to promote accountability and coordination of care through the creation of ACOs. The program will allow hospitals, physicians and others to form ACOs and work together to invest in infrastructure and redesign integrated delivery processes to achieve high quality and efficient delivery of services. ACOs that achieve quality performance standards will be eligible to share in a portion of the amounts saved by the Medicare program. DHHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. In November 2011, CMS published the final rules regarding ACOs, and in June 2015, CMS issued a final rule to update and improve policies governing the MSSP. These regulations are complex and it remains unclear whether the qualification requirements will be a formidable barrier. It is probable that hospital participants in ACOs will have to

marshal a large upfront financial investment to form unique and untested ACO structures, which may or may not succeed in gaining qualification. For those that do qualify, it is not clear if the savings will be adequate to recoup the initial investment. In addition, although a continued interim final rule extends the fraud and abuse waivers until November 2015, there may remain regulatory risks for participating hospitals, as well as financial and operational risks. The applicable regulating bodies have published guidance for ACOs to follow in order to comply with the law, but the published guidance is complex. In particular, since the federal ACO regulation would not preempt state law, providers in any state participating as a federal ACO must be organized and operated in compliance with such state's existing statutes and regulations. Numerous organizations have formed ACOs and have been selected by CMS to participate in the MSSP. In addition, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change. The potential impacts of these initiatives and the regulation for ACOs are unknown, but introduce greater risk and complexity to health care finance and operations.

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

Physician Supply. Sufficient community-based physician supply is important to hospitals and health systems. CMS annually reviews overall physician reimbursement formulas for Medicare and Medicaid. Changes to such physician reimbursement formulas by CMS could lead to physicians ceasing to accept Medicare and/or Medicaid patients or locating their practices in communities with lower Medicare populations. Hospitals and health systems may be required to invest additional resources in recruiting and retaining physicians, or may be required to increase the percentage of employed physicians in order to continue serving the growing population base and maintain market share.

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

Specialty health care facilities or ventures that attract an important segment of an existing hospital's admitting specialists and services that generate significant revenue may be particularly damaging. For example, some large hospitals may have significant dependence on cardiovascular and/or orthopedic surgery programs, as revenue streams from those programs may cover significant fixed overhead costs. If a significant component of such a hospital's cardiovascular or orthopedic surgeons develop their own specialty hospital or surgery center (alone or in conjunction with a specialty hospital operator or promoter, the number of which is growing) taking with them their patient base, a hospital could experience a rapid and dramatic decline in net revenues that is not proportionate to the number of patient admissions or patient days lost. It is also possible that the competing specialty entity, as a for-profit venture, would not accept indigent patients or other payers and government programs, leaving low-pay patient populations in the full-service hospital. In certain cases, such an event could be materially adverse to a hospital. A variety of proposals have been advanced to permanently prohibit such investments. Nonetheless, a prior governmental moratorium on certain specialty hospitals has been lifted, and therefore specialty hospitals may continue to represent a competitive challenge for full-service hospitals. Various state and federal regulations have also been proposed to restrict certain structures of joint ventures between and among hospitals and physicians.

Freestanding ambulatory surgery centers may attract away significant commercial outpatient services traditionally performed at hospitals. Commercial outpatient services, currently among the most profitable for hospitals, may be lost to competitors who can provide these services in an alternative, less costly setting. Full-

service hospitals rely upon the revenues generated from commercial outpatient services to fund other less profitable services, and the decline of such business may result in the significant reduction of profitable income. Competing ambulatory surgery centers, more likely a for-profit business, may not accept indigent patients or low paying programs and would leave these populations to receive services in the hospital setting. Consequently, hospitals are vulnerable to competition from ambulatory surgery centers.

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

Antitrust. Antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, payer contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, certain pricing or salary setting activities, and anticompetitive business conduct or practices. The application of the federal and state antitrust laws to health care is evolving (especially as the ACA is implemented), and therefore not always clear. Currently, the most common areas of potential liability for hospitals and other health care providers are joint action among providers with respect to payer contracting, medical staff credentialing disputes and anticompetitive business conduct or practices by hospitals and other health care providers with sufficiently large market share.

Violation of the antitrust laws could result in criminal and/or civil enforcement proceedings by federal and state agencies, as well as actions by private litigants. In certain actions, private litigants may be entitled to treble damages, and in others, governmental entities may be able to assess substantial monetary fines. Moreover, successful private or governmental litigants may obtain injunctive relief that can affect the defendant's ability to conduct or continue certain business practices or activities.

Labor Relations and Collective Bargaining. Hospitals are large employers with a wide diversity of employees. Increasingly, employees of hospitals are becoming unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to hospitals. Employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and hospital reputation. See APPENDIX A – "ALLINA HEALTH SYSTEM – EMPLOYEES" for information about union representation at Allina Health.

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

Staffing. From time to time, the health care industry suffers from a scarcity of nursing personnel, respiratory therapists, pharmacists and other trained health care technicians. In addition, aging medical staffs and difficulties in recruiting individuals to the medical profession are predicted to result in physician shortages. A significant factor underlying this trend includes a decrease in the number of persons entering such professions. This is expected to intensify in the future, aggravating the general shortage and increasing the likelihood of hospital-specific shortages. Competition for physicians and other health care professionals, coupled with increased recruiting and retention costs may increase hospital operating costs, possibly significantly. This trend could have a material adverse impact on the financial conditions and results of operations of hospitals. This scarcity may further be intensified if utilization of health care services increases as a consequence of the ACA's expansion of the number of insured consumers.

Professional Liability Claims and General Liability Insurance. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against hospitals and other health care providers. Insurance does not provide coverage for judgments for punitive damages.

Beginning in 2008, CMS refused to reimburse hospitals for medical costs arising from certain "never events," which include specific preventable medical errors. Certain private insurers and HMOs followed suit. The occurrence of "never events" is more likely to be publicized and may negatively impact a hospital's reputation, thereby reducing future utilization and potentially increasing the possibility of liability claims

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

There is no assurance that Allina Health will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover malpractice judgments rendered against Allina Health or that such coverage will be available at a reasonable cost in the future. For a description of insurance coverage maintained by Allina Health, see APPENDIX A – "ALLINA HEALTH SYSTEM – INSURANCE PROGRAM."

Information Technology. The ability to adequately price and bill health care services and to accurately report financial results depends on the integrity of the data stored within information systems, as well as the operability of such systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards. There can be no assurance that efforts to upgrade and expand information systems capabilities, protect and enhance these systems, and develop new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future.

Electronic media is also increasingly being used in clinical operations, including the conversion from paper to electronic medical records, computerization of order entry functions and the implementation of clinical decision-support software. The reliance on information technology for these purposes imposes new expectations on physicians and other workforce members to be adept in using and managing electronic systems. It also introduces risks related to patient safety, and to the privacy, accessibility and preservation of health information. See "Regulatory Environment – HIPAA; Privacy Requirements" and "Cybersecurity Risks" above. Technology malfunctions or failure to understand and use information systems properly could result in the dissemination of or reliance on inaccurate information, as well as in disputes with patients, physicians and other health care professionals. Health information systems may also be subject to different or higher standards or greater regulation than other information technology or the paper-based systems previously used by health care providers, which may increase the cost, complexity and risks of operations. All of these risks may have adverse consequences on hospitals and health care providers.

Facility Damage. Health care providers are highly dependent on the condition and functionality of their physical facilities. Damage from natural causes, fire, deliberate acts of destruction, or various facility system failures may have a material adverse impact on hospital operations, financial conditions and results of operations.

Tax-Exempt Status and Other Tax Exemption; Tax Audits

Maintenance of the Tax-Exempt Status of Allina Health or any future Tax-Exempt Credit Group Member. The tax-exempt status of tax-exempt obligations depends upon Allina Health and any future Credit Group Member benefiting from the use of tax-exempt bond proceeds maintaining their status as organizations described in Section 501(c)(3) of the Code (a "501(c)(3)") or as a disregarded entity for federal tax purposes whose sole member is a 501(c)(3) (each a "Benefitting Member"). The maintenance of status as a 501(c)(3) is contingent on compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and other permissible purposes and their avoidance of transactions that may cause their earnings or assets to inure to the benefit of private individuals. As these general

principles were developed primarily for public charities that do not conduct large-scale business operations and activities, they often do not adequately address the myriad of operations and transactions entered into by a modern health care organization. Although traditional activities of health care providers, such as medical office building leases, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities or categories of activities have not been fully addressed in any official opinion, interpretation or policy of the IRS.

The ACA also contains new requirements for tax-exempt hospitals. Under the ACA, each tax-exempt hospital facility is required to (i) conduct a community health needs assessment at least every three years and adopt an implementation strategy to meet the identified community needs, (ii) adopt, implement and widely publicize a written financial assistance policy and a policy to provide emergency medical treatment without discrimination, (iii) limit charges to individuals who qualify for financial assistance under such tax-exempt hospital's financial assistance policy to no more than the amounts generally billed to individuals who have insurance covering such care and refrain from using "gross charges" when billing such individuals, and (iv) refrain from taking extraordinary collection actions without first making reasonable efforts to determine whether the individual is eligible for assistance under such tax-exempt hospital's financial assistance policy. In addition, the Treasury Department is required to review information about each tax-exempt hospital's community benefit activities at least once every three years, as well as to submit an annual report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, and costs incurred by tax-exempt hospitals for community benefit activities. The periodic reviews and reports to Congress regarding the community benefits provided by 501(c)(3) hospitals may increase the likelihood that Congress will require such hospitals to provide a minimum level of charity care in order to retain tax-exempt status and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

On December 29, 2014, the Secretary of the Treasury issued final regulations under Section 501(r) of the Code that provide detailed and comprehensive guidance relating to requirements for community health needs assessments, financial assistance policies, emergency medical care policies, limitations on charges and billing and collection practices, and also provide guidance on consequences of failure to satisfy Section 501(r) requirements. These final regulations are complex and may be administratively burdensome to implement. Generally, the regulations apply to tax years beginning after December 29, 2015, and provide that a hospital organization may rely on a reasonable, good faith interpretation of the Section 501(r) requirements for tax years beginning on or before December 29, 2015, which may include compliance with certain prior proposed regulations under Section 501(r).

Allina Health participates in a variety of transactions with physicians either directly or indirectly. Management of Allina Health believes that the transactions to which Allina Health is a party are consistent with the requirements of the Code as to tax-exempt status, but, as noted above, there is uncertainty as to the state of the law.

The IRS has periodically conducted audit and other enforcement activity regarding tax-exempt health care organizations. Such audits may be conducted by teams of revenue agents, often take years to complete and require the expenditure of significant staff time by both the IRS and taxpayers. These audits may involve examination of a wide range of possible issues, including tax-exempt bond financings, partnerships and joint ventures, retirement plans and employee benefits, employment taxes, political contributions and other matters.

Allina Health has been and most likely will be audited from time to time by the IRS. Allina Health believes it has properly complied with tax laws related to its tax-exempt status and to any tax-exempt debt issued for its benefit. Nevertheless due to the complexity of tax laws, including issues about which reasonable persons can differ, an audit could result in additional taxes, interest and penalties. An audit could ultimately affect Allina Health's tax-exempt status as well as the exclusion from gross income for federal income tax purposes of the interest payable with respect to tax-exempt debt issued for the benefit of Allina Health.

If the IRS were to find that a hospital or health care system has participated in activities in violation of certain regulations or rulings, the tax-exempt status of such entity could be in jeopardy. Although the IRS has not frequently revoked the 501(c)(3) tax-exempt status of nonprofit health care organizations, it could do so in the future. Loss of tax-exempt status by Allina Health or any future Benefitting Member potentially could result in loss of tax exemption of tax-exempt debt of Allina Health or any future Benefitting Member. Defaults in covenants regarding the tax-exempt debt and obligations likely would be triggered. Loss of tax-exempt status also could result in substantial tax liabilities on income of Allina Health. In some cases, the IRS has imposed substantial monetary

penalties on tax-exempt hospitals in lieu of revoking their tax-exempt status. In those cases, the IRS and exempt hospitals entered into closing agreements requiring substantial payments to the IRS. For these reasons, loss of tax-exempt status of Allina Health or any future Benefitting Member could have a material adverse effect on the financial condition of Allina Health.

In lieu of revocation of exempt status, the IRS may impose penalty excise taxes on certain "excess benefit transactions" involving 501(c)(3) organizations and "disqualified persons." An excess benefit transaction is one in which a disqualified person or entity receives more than fair market value from the exempt organization or pays the exempt organization less than fair market value for property or services, or shares the net earnings of the tax-exempt entity. A disqualified person is a person (or an entity) who is in a position to exercise substantial influence over the affairs of the exempt organization during the five years preceding an excess benefit transaction. The statute imposes excise taxes on the disqualified person and any "organization manager" who knowingly participates in an excess benefit transaction. These rules do not penalize the exempt organization itself, so there would be no direct impact on Allina Health or any future tax-exempt Credit Group Member or the tax status of tax-exempt debt if an excess benefit transaction were subject to IRS enforcement, pursuant to these "intermediate sanctions" rules.

State and Local Tax Exemption. The states may also scrutinize the income tax exemption of health care organizations. It is possible that legislation in the state of Minnesota and Wisconsin may be proposed to strengthen its role in supervising nonprofit health systems. It is likely that the loss by Allina Health or any future tax-exempt Credit Group Member of federal income tax exemption would also trigger a challenge to its state income tax exemption. Depending on the circumstances, such event could be material and adverse.

State, county (or parish) and local taxing authorities undertake audits and reviews of the operations of tax-exempt health care providers with respect to their real property tax exemptions. In some cases, particularly where authorities are dissatisfied with the amount of services provided to indigents, the real property tax-exempt status of the health care providers has been questioned. The majority of the hospital real property of Allina Health is currently treated as exempt from real property taxation. Although the real property tax exemptions of Allina Health with respect to its core hospital facilities, have not, to the knowledge of management, been under challenge or investigation, an audit could lead to a challenge that could adversely affect the real property tax exemptions of Allina Health.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of nonprofit corporations. There can be no assurance that future changes in the laws and regulations of state or local governments will not materially adversely affect the financial condition of Allina Health by requiring payment of income, sales, local property or other taxes.

Unrelated Business Income. In recent years, the IRS and state, county and local tax authorities have audited the operations of tax-exempt hospitals and health care systems with respect to their exempt activities and the generation of unrelated business taxable income ("UBTI"). Most hospitals and health care systems participate in activities that may generate UBTI. An investigation or audit could result in assessment of taxes, interest and penalties with respect to unreported UBTI and in some cases ultimately could affect the tax-exempt status of such entity, as well as the exclusion from gross income for federal income tax purposes of the interest payable on tax-exempt debt of Allina Health.

Maintenance of Tax-Exempt Status of Interest on Tax-Exempt Debt. Tax-exempt bonds have previously been issued for the benefit of Allina Health and are outstanding. IRS officials have indicated that more resources will be invested in audits of tax-exempt bonds, including the use of their proceeds, in the charitable organization sector, with specific reviews of private use. In addition, the IRS sent post-issuance compliance questionnaires to several hundred nonprofit corporations that have borrowed on a tax-exempt basis regarding their post-issuance compliance with various requirements for maintaining the federal tax exemption of interest on their tax-exempt bonds. The questionnaire included questions relating to the borrower's (i) record retention, which the IRS has particularly emphasized, (ii) qualified use of tax-exempt bond-financed property, (iii) arbitrage yield restriction and rebate requirements, (iv) debt management policies, and (v) voluntary compliance and education. In the final report, issued July 1, 2011, summarizing the findings and conclusions of the questionnaires, the IRS stressed the importance of formal post-issuance compliance and record-keeping procedures which, once implemented, should continuously be reviewed. IRS representatives have indicated that more questionnaires will be sent to additional nonprofit organizations.

The IRS Form 990-Return of Organization Exempt From Income Tax is used by certain exempt organizations, including 501(c)(3)s, to submit information required by the federal government to maintain tax-exemption. The Form 990 requires detailed public disclosure of compensation practices, corporate governance, loans to management and others, joint ventures and other types of transactions, political campaign activities and other areas the IRS deems to be compliance risk areas. As mentioned above in "BONDHOLDERS' RISKS – Nonprofit Health Care Environment – IRS Examinations of Compensation and Community Benefit Practices," effective with the 2009 tax year, tax-exempt organizations must also complete new schedules to the Form 990, which create additional reporting responsibilities. On Schedule H, hospitals and health systems must report how they provide community benefit and specify certain billing and collection practices. Schedule K requires detailed information related to all outstanding tax-exempt bond issues of tax-exempt borrowers, including information regarding operating, management and research contracts as well as private use compliance. Tax-exempt organizations must also complete Schedule J, which requires reporting of compensation information for the organizations' current (and certain former) officers, directors, trustees, key employees, and highest compensated employees. There can be no assurance that responses by management of Allina Health to a questionnaire or Form 990 will not lead to an IRS review that could adversely affect the market value or marketability of outstanding tax-exempt indebtedness of Allina Health.

Limitations on Contractual and Other Arrangements Imposed by the Internal Revenue Code. As a tax-exempt organization, Allina Health is limited with respect to its use of practice income guarantees, reduced rent on medical office space, low interest loans, joint venture programs and other means of recruiting and retaining physicians. Uncertainty in this area has been reduced somewhat by the issuance by the IRS of guidelines on permissible physician recruitment practices. The IRS scrutinizes a broad variety of contractual relationships commonly entered into by hospitals and health care systems and has issued a detailed audit guide suggesting that field agents scrutinize numerous activities of hospitals and health care systems in an effort to determine whether any action should be taken with respect to limitations on or revocation of their tax-exempt status or assessment of additional tax. Any suspension, limitation, or revocation of Allina Health's or any future Benefitting Member's tax-exempt status or assessment of significant tax liability would have a materially adverse effect on Allina Health and might lead to loss of tax exemption of interest on tax-exempt debt of Allina Health.

Other Risk Factors

Investments. Allina Health has significant holdings in a broad range of investments. Market fluctuations may affect the value of those investments and those fluctuations may be and historically have been at times material.

Pension and Benefit Funding. As large employers, hospitals may incur significant expenses to fund pension and benefit plans for employees and former employees, and to fund required workers' compensation benefits. Plans are often underfunded, or may become underfunded and funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed for other purposes.

Allina participates in certain multi-employer plans that cover certain of its unionized employees. If any of the contributing employers defaults on its plan obligations, then the funding liability of the defaulting employer would become the responsibility of the remaining employers. The amount of such liability could be material. For further information about Allina's employee retirement plans see also APPENDIX A – "ALLINA HEALTH SYSTEM – EMPLOYEE RETIREMENT PLANS."

Risks Related to Variable Rate Obligations. Certain outstanding securities secured by Obligations issued under the Master Indenture are variable interest rate obligations, the interest rates on which could rise. Such interest rates vary on a periodic basis and may be converted to a fixed interest rate. This protection against rising interest rates is limited, however, because Allina Health would be required to continue to pay interest at the variable rate until it is permitted to convert the obligations to a fixed rate pursuant to the terms of the applicable transaction documents. Previous credit market turmoil in the auction rate markets and dislocation among various bond insurers and swap providers previously triggered suddenly high interest costs to many health care organizations holding debt with interest rates that varied on a periodic basis.

In addition, such variable rate bonds are subject to optional and mandatory tender for purchase under certain circumstances. Obligations under the Master Indenture have previously been issued to the providers of credit and liquidity facilities including those supporting certain variable rate bonds. The agreements with such providers include representations and covenants by Allina Health in addition to those included in the Master Indenture. The breach of a provision of any such agreement could result in the declaration of an event of default under such agreement and, under certain circumstances, could result in the declaration by the Master Trustee of an event of default under the Master Indenture. The additional covenants in these agreements may be waived or amended by the applicable party or parties without the consent of, or any notice to, the Master Trustee, the Bond Trustee or the holders of the Bonds. Upon the occurrence of an event of default under any of these agreements, the outstanding amount due under any such agreement could be declared immediately due and payable. The acceleration of amounts due any of these agreements could have a material adverse effect on the cash position and financial condition of the Obligated Group. See APPENDIX A – "ALLINA HEALTH SYSTEM – INVESTMENT MANAGEMENT – Debt and Swap Structure."

Risks Related to Interest Rate Swaps. Allina Health is a party to several interest rate swaps (the "Swaps"). Interest rate swaps have experienced negative trading patterns, causing many to cease to function effectively to hedge interest rate exposure. Certain swap arrangements may be terminated by the counterparty and many may not be terminable except upon the payment of potentially significant termination fees by the borrowing party. In some cases, negative "mark-to-market" valuation of certain swap arrangements must be booked on a borrower's balance sheet. These factors may have a material adverse impact on health systems involved in such arrangements. For a discussion of Allina Health's swap arrangements, see APPENDIX A – "ALLINA HEALTH SYSTEM – INVESTMENT MANAGEMENT – Debt and Swap Structure."

Pursuant to some swap arrangements, the counterparty will be obligated to make payments to Allina Health, which payments may be more or less than the interest rates Allina Health is required to pay with respect to a comparable principal amount of the related indebtedness. No determination can be made at this time as to the potential exposure to Allina Health relating to the difference in variable rate payments.

The Swaps are secured under the Master Indenture. Allina Health may in the future enter into additional interest rate swap agreements and other financial product and hedge devices that are also secured under the Master Indenture.

Bond Ratings. There is no assurance that the ratings assigned to the Bonds will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for and marketability of the Bonds. See also "RATINGS" herein.

Bankruptcy and Insolvency. In the event that Allina Health or any future Members of the Obligated Group filed for protection from creditors under the United States Bankruptcy Code, the rights and remedies of the Owners of the Bonds would be subject to various provisions of the United States Bankruptcy Code. If Allina Health or any future Members of the Obligated Group were to commence a proceeding in bankruptcy, payments made by such Members of the Obligated Group during the 90-day period immediately preceding such commencement (or, under certain circumstances, during the preceding one-year period) may be voided as preferential transfers to the extent such payments allow the recipients thereof to receive more than they would have received in the event of the liquidation of such Members of the Obligated Group. Security interests and other liens granted by Allina Health and any future Members of the Obligated Group to the Bond Trustee or the Master Trustee and perfected during such preference period may also be voided as preferential transfers to the extent such security interest or other lien secures obligations that arose prior to the date of such grant or perfection.

A bankruptcy filing would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against such Members of the Obligated Group and their respective property and as an automatic stay of any act or proceeding to enforce a lien upon or to otherwise exercise control over its property as well as various other actions to enforce, maintain or enhance the rights of the Bond Trustee and the Master Trustee. If the bankruptcy court so ordered, the property of such Members of the Obligated Group, including their respective Pledged Revenues, could be used for the financial rehabilitation of such Members of the Obligated Group despite any security interest of the Bond Trustee therein. The rights of the Bond Trustee and the Master Trustee to enforce their respective interests and other liens could be delayed during the pendency of the rehabilitation proceeding.

Such Members of the Obligated Group could also file a plan for the adjustment of its debts in any such proceeding which could include provisions modifying or altering the rights of creditors generally, or any class of them, secured or unsecured. The plan, when confirmed by a court, binds all creditors who had notice or knowledge of the plan and, with certain exceptions, discharges all claims against the debtor to the extent provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are conditions that the plan be feasible and that it shall have been accepted by each class of claims impaired thereunder. Each class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the class cast votes in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly. Any such plan could adversely affect the Owners and Beneficial Owners of the Bonds. In addition, a Bankruptcy Court may, under certain conditions, avoid or strip the liens off of certain of the Obligated Group's assets, which could include security interests granted to the Master Trustee for the benefit of Holders of Obligations, including the Series 2015 Obligation.

In the event of bankruptcy or insolvency of Allina Health or any future Members of the Obligated Group, there is no assurance that certain covenants, contained in the Bond Indenture or the Master Indenture and certain other documents would survive.

In addition, the bankruptcy of a health plan or physician group that is a party to a significant managed care arrangement with the Obligated Group or any of its affiliates, or that of any significant contract payer obligated to any one or more of the Obligated Group or its affiliates, could have material adverse effects on the Obligated Group.

Construction Delays and Cost Overruns. Allina Health is currently undertaking a number of construction projects, and is expected to undertake additional projects in the future. Completion of such projects is subject to approval by the appropriate governmental bodies. In addition, numerous risks are involved in any such projects, including delays and increased costs due to strikes, shortages of materials, adverse weather conditions, changes in project design, inflation, and numerous other factors. Therefore, there can be no assurances that the projects currently pursued or undertaken in the future by Allina Health will be finished on time or within budget. See APPENDIX A – "ALLINA HEALTH SYSTEM – FINANCIAL INFORMATION – Capital Expenditures."

Other Future Risks. In the future, the following factors, among others, may adversely affect the operations of hospitals and other health care providers, including Allina Health, or the market value of the Bonds, to an extent that cannot be determined at this time.

(a) Adoption of legislation or implementation of regulations that would establish a national or statewide single-payer health program or that would establish national, statewide or otherwise regulated rates applicable to hospitals and other health care providers.

(b) Reduced demand for the services of hospitals and other health care providers that might result from decreases in population or loss of market share or changes in sources of revenue and case mix intensity.

(c) Consolidation of managed care plans or other payers.

(d) Bankruptcy of an indemnity/commercial insurer, managed care plan or other payer.

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

(f) Efforts by employers to shifts costs of medical care to employees through increased deductibles and restrictions on covered services.

(g) The occurrence of a pandemic or a natural or man-made disaster that could damage hospitals and other health care providers' facilities, interrupt utility service to the facilities, result in an abnormally high demand for health care services or workforce loss or otherwise impair Allina Health's operations and the generation of revenues from the facilities. See APPENDIX A – "ALLINA HEALTH SYSTEM – INSURANCE PROGRAM."

(h) Limitations on the availability of, and increased compensation necessary to secure and retain, nursing, technical and other professional personnel.

(i) Increasing deficits and other financial pressure experienced by both state and federal governments that result in significant reductions or delays in payments from governmental payers, especially Medicare and Medicaid.

(j) An inflationary economy without corresponding increases in revenue could result from, among other factors: increases in the salaries, wages and fringe benefits of employees; increases in costs associated with advances in medical technology or with inflation; or future legislation which would prevent or limit the ability of hospitals to increase revenues.

(k) Competition from other health care providers now or hereafter located in the service area of Allina Health

(l) Efforts by taxing authorities to impose or increase taxes related to the property and operations of nonprofit organizations or to cause nonprofit organizations to increase the amount of services provided to indigents to avoid the imposition or increase of such taxes.

(m) A limitation or setting of the rates charged for services furnished to private paying patients. The State of Minnesota currently does not have such a program. If any such program limiting or setting rates were established, it may have an adverse effect on the revenues of Allina Health.

NO LITIGATION

There is no action, suit, proceeding, inquiry or investigation at law or before or by any court, public board or body known to management of Allina Health to be pending, or threatened, against Allina Health nor, to its knowledge, is there any basis therefor, wherein an unfavorable decision, ruling or finding would adversely affect the issuance, execution or delivery by Allina Health of the Bonds or the validity of the Bonds, the Bond Indenture, the Series 2015 Obligation or the Master Indenture.

Allina Health is subject to certain legal actions that, in whole or in part, are not or may not be covered by insurance because of the type of action or amount or types of damages requested (e.g., punitive damages), because of a reservation of rights by an insurance carrier, or because the action has not proceeded to a stage that permits full evaluation. Management of Allina Health does not anticipate that any such suits will ultimately result in damage awards or judgments that would materially adversely affect the operations or financial condition of Allina Health.

There is no litigation of any nature now pending against Allina Health, to the knowledge of management of Allina Health, threatened, which, if successful, would materially adversely affect the operations or financial condition of Allina Health.

RATINGS

Standard & Poor's Rating Services ("Standard & Poor's"), Moody's Investors Service, Inc. ("Moody's") and Fitch Ratings ("Fitch") have provided ratings for the Bonds of "AA-", "Aa3" and "AA-", respectively. Allina Health has furnished to Standard & Poor's, Moody's and Fitch certain information and materials concerning the Bonds and itself. Generally, rating agencies base their ratings on such information and materials and on investigations, studies and assumptions made by the rating agencies themselves. These ratings reflect only the view of such organizations, and an explanation of the significance of such ratings may be obtained only from the rating agency furnishing such rating. There is no assurance that such ratings will be maintained for any given period of

time or that such ratings will not be revised downward, suspended or withdrawn entirely by such rating agencies, if in their sole judgment, circumstances so warrant. Other than as set forth under "CONTINUING DISCLOSURE" below, Allina Health has not and the Underwriters have not undertaken any responsibility either to bring to the attention of the Holders or beneficial owners of the Bonds any proposed revision, suspension or withdrawal of any rating on the Bonds or to oppose any such proposed revision, suspension or withdrawal. Any such downward revision, suspension or withdrawal of such ratings may have an adverse effect on the market price or marketability of the Bonds. A securities rating is not a recommendation to buy, sell or hold securities.

FINANCIAL ADVISOR

Allina Health has retained Kaufman, Hall & Associates, LLC., Skokie, Illinois, as financial advisor in connection with the issuance of the Bonds. Although Kaufman, Hall & Associates, LLC. has assisted in the preparation of this Offering Memorandum, Kaufman, Hall & Associates, LLC. was not and is not obligated to undertake, and has not undertaken to make, an independent verification and assumes no responsibility for the accuracy, completeness or fairness of the information contained in this Offering Memorandum.

UNDERWRITING

The Bonds are being purchased by J.P. Morgan Securities LLC, as representative (the "Representative") of itself and Piper Jaffray & Co., U.S. Bancorp Investments, Inc. and Wells Fargo Securities, LLC (collectively, the "Underwriters"). Pursuant to the Bond Purchase Contract for the Bonds, the Representative has agreed to purchase the Bonds at a purchase price of $248,250,000 (consisting of the aggregate principal amount of the Bonds of $250,000,000 less an underwriting discount of $1,750,000). The Purchase Contract for the Bonds provides that the Representative will purchase all of the Bonds, if any are purchased, and contains the agreements of Allina Health to indemnify the Underwriters against certain liabilities, including certain liabilities under federal securities law.

J.P. Morgan Securities LLC ("JPMS"), one of the Underwriters of the Bonds, has entered into negotiated dealer agreements (each, a "Dealer Agreement") with each of Charles Schwab & Co., Inc. ("CS&Co.") and LPL Financial LLC ("LPL") for the retail distribution of certain securities offerings at the original issue prices. Pursuant to each Dealer Agreement, each of CS&Co. and LPL may purchase Bonds from JPMS at the original issue price less a negotiated portion of the selling concession applicable to any Bonds that such firm sells.

Piper Jaffray & Co., one of the Underwriters of the Bonds, and Pershing LLC, a subsidiary of The Bank of New York Mellon Corporation, entered into an agreement (the "Agreement") which enables Pershing LLC to distribute certain new issue municipal securities underwritten by or allocated to Piper Jaffray & Co., including the Bonds. Under the Agreement, Piper Jaffray & Co. will share with Pershing LLC a portion of the fee or commission paid to Piper Jaffray & Co.

US Bancorp is the marketing name of U.S. Bancorp and its subsidiaries, including U.S. Bancorp Investments, Inc. ("USBII"), which is serving as one of the Underwriters of the Bonds.

Wells Fargo Securities is the trade name for certain securities-related capital markets and investment banking services of Wells Fargo & Company and its subsidiaries, including Wells Fargo Securities, LLC ("WFS"), member NYSE, FINRA, NFA, and SIPC.

CERTAIN RELATIONSHIPS

The Underwriters and their respective affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage activities. Certain of the Underwriters and their respective affiliates have, from time to time, performed, and may in the future perform, various investment banking services for Allina Health and its affiliates for which they received or will receive customary fees and expenses.

In the ordinary course of their various business activities, the Underwriters and their respective affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities) and financial instruments (which may include bank loans and/or credit default swaps) for their own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of, or issued for the benefit of, Allina Health or its affiliates.

Mark Jordahl, a member of Allina Health's Board of Directors, is President, Wealth Management Group at U.S. Bank, National Association, an affiliate of one of the Underwriters.

Deb Schoneman, a member of Allina Health's Board of Directors, is the Chief Financial Officer of Piper Jaffray Companies, an affiliate of one of the Underwriters.

Wells Fargo Bank, National Association, an affiliate of WFS, one of the Underwriters for the Bonds, serves as Bond Trustee and Master Trustee relating to the Bonds.

Darrell Tukua, a member of Allina Health's Board of Directors, is a retired partner of KPMG LLP, the independent auditors retained by Allina Health to review its consolidated financial statements.

CONTINUING DISCLOSURE

Allina Health will covenant for the benefit of Holders and Beneficial Owners of the Bonds to provide for dissemination (i) certain financial information and operating data not later than 150 days following the end of the Credit Group's fiscal year (which currently is December 31) (referred to as the "Annual Report"), commencing with the report for the December 31, 2015 fiscal year, (ii) within 45 days after the end of each fiscal quarter of each year, commencing with the fiscal quarter ending September 30, 2015, certain unaudited financial information and (iii) notices of the occurrence of certain enumerated events. The Annual Report, quarterly information and notices of certain enumerated events, if any, will be filed by Allina Health, as Obligated Group Agent, or its dissemination agent with the Municipal Securities Rulemaking Board (the "MSRB"). Since the Bonds are taxable securities issued directly by Allina Health, the Electronic Municipal Market Access ("EMMA") website of the MSRB is not directly available for the filing of annual or quarterly reports or listed event notices relating to the Bonds. Allina Health will, however, file such reports and notices on EMMA so long as it has tax-exempt bonds outstanding, using the CUSIP numbers for such tax-exempt bonds. If no such tax-exempt bonds are outstanding, Allina Health will make such reports and notices available through any other nationally recognized disclosure site or through Allina Health's website. See APPENDIX D – "FORM OF CONTINUING DISCLOSURE UNDERTAKING." In the last five years Allina Health has never failed to comply in all material respects with its obligations under any previous continuing disclosure undertaking to provide annual or quarterly reports or notices of material events.

CERTAIN UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS

The following discussion summarizes certain U.S. federal income tax considerations generally applicable to holders of the Bonds that acquire their Bonds in the initial offering at the issue price (i.e., the price at which a substantial amount of the Bonds are sold to the public) and who will hold their Bonds as "capital assets" within the meaning of Section 1221 of the Code. The discussion below is based upon laws, regulations, rulings, and decisions in effect and available on the date hereof, all of which are subject to change, possibly with retroactive effect. No rulings have been or are expected to be sought from the IRS with respect to any of the U.S. federal tax consequences discussed below, and no assurance can be given that the IRS will not take contrary positions. Further, the following discussion does not deal with U.S. tax consequences applicable to any given investor, nor does it address the U.S. tax considerations applicable to all categories of investors, some of which may be subject to special tax rules, such as certain U.S. expatriates, banks, real estate investment trusts, regulated investment companies, insurance companies, tax-exempt organizations, dealers or traders in securities or currencies, partnerships or other pass-through entities, investors that hold their Bonds as part of a hedge, straddle or an integrated or conversion transaction, or investors whose "functional currency" is not the U.S. dollar. Furthermore, it does not address alternative minimum tax consequences, the net investment income tax imposed under Section 1411 of the Code, estate and gift tax consequences, or the taxation of the Bonds under state, local or non-U.S. tax laws.

As used herein, "U.S. Holder" means a beneficial owner of a Bond that for U.S. federal income tax purposes is (1) an individual who is a citizen or resident of the United States, (2) a corporation created or organized in or under the laws of the United States or any state thereof (including the District of Columbia), (3) an estate the income of which is subject to U.S. federal income taxation regardless of its source or (4) a trust if a court within the United States is able to exercise primary supervision over the administration of the trust and one or more United States persons (as defined in the Code) have the authority to control all substantial decisions of the trust (or a trust that has made a valid election under U.S. Treasury Regulations to be treated as a domestic trust). As used herein, "Non-U.S. Holder" generally means a beneficial owner of a Bond that is not a U.S. Holder.

Prospective investors should consult their own tax advisors in determining the U.S. federal, state, local or non-U.S. tax consequences to them from the purchase, ownership and disposition of the Bonds in light of their particular circumstances.

U.S. Holders

Interest. Interest on the Bonds generally will be taxable to a U.S. Holder as ordinary interest income at the time such amounts are accrued or received, in accordance with the U.S. Holder's method of accounting for U.S. federal income tax purposes.

To the extent that the issue price of the Bonds is less than the amount to be paid on the Bonds (excluding amounts stated to be interest and payable at least annually over the term of such Bonds), the difference may constitute original issue discount ("OID"). U.S. Holders of Bonds generally will be required to include any OID in income for U.S. federal income tax purposes as it accrues, in accordance with a constant-yield method based on a compounding of interest (which may be before the receipt of cash payments attributable to such income). Under this method, U.S. Holders generally will be required to include in income increasingly greater amounts of OID in successive accrual periods. Solely for the purposes of calculating OID, it is assumed that Allina Health will exercise an option to redeem the Bonds if such exercise would lower the yield to maturity of the Bonds.

A U.S. Holder that purchases a Bond for an amount in excess of the principal amount payable at maturity (or, in some cases, at their earlier call date) may make an election to amortize such premium using a constant-yield method over the term of such Bond, in which case the amount required to be included in the U.S. Holder's income each year with respect to interest on the Bond will be reduced by the amount of amortizable bond premium allocable (based on the Bond's yield to maturity) to that year. Any election to amortize bond premium will apply to all debt securities (other than debt instruments the interest on which is excludible from gross income) held by the U.S. Holder at the beginning of the first taxable year to which the election applies or thereafter acquired by the U.S. Holder.

Sale or Other Disposition of the Bonds. A U.S. Holder generally will recognize gain or loss on the sale or other disposition of a Bond equal to the difference between (i) the amount of cash plus the fair market value of property received (except to the extent attributable to accrued but unpaid interest on the Bond, which will be taxed in the manner described above) and (ii) the U.S. Holder's adjusted U.S. federal income tax basis in the Bond (generally, the purchase price paid by the U.S. Holder for the Bond, decreased by any amortized premium, and increased by the amount of any OID previously included in income by such U.S. Holder with respect to such Bond). Any such gain or loss generally will be capital gain or loss. In the case of a non-corporate U.S. Holder of the Bonds, the maximum marginal U.S. federal income tax rate applicable to any such gain is currently lower than the maximum marginal U.S. federal income tax rate applicable to ordinary income if such U.S. holder's holding period for the Bonds exceeds one year. The deductibility of capital losses is subject to limitations.

Information Reporting and Backup Withholding. Information returns may be filed with the IRS in connection with payments on the Bonds and the proceeds from a sale, retirement, exchange or other disposition of the Bonds. A U.S. Holder will be subject to backup withholding on these payments if the holder fails timely to provide the holder's correct taxpayer identification number to the payer and comply with certain certification procedures or otherwise establish an exemption from backup withholding. Amounts withheld under the backup withholding rules may be refunded or credited against the U.S. Holder's federal income tax liability, if any, provided that the required information is timely furnished to the IRS. Certain U.S. Holders (including among others, corporations and certain tax-exempt organizations) are not subject to backup withholding.

Non-U.S. Holders

Interest. Subject to the discussions below under the headings "Information Reporting and Backup Withholding" and "Foreign Account Tax Compliance," payments on a Bond to a Non-U.S. Holder generally will not be subject to U.S. federal withholding tax, provided that, in the case of interest or OID, (1) the holder is not a "10-percent shareholder" of Allina Health, within the meaning of Section 871(h)(3) of the Code, or a controlled foreign corporation, as such term is defined in the Code, which is related to Allina Health through stock ownership and (2) the beneficial owner of the Bond provides a statement signed under penalties of perjury that includes its name and address and certification that it is not a United States person in compliance with applicable statutory and regulatory requirements.

Sale or Other Disposition of the Bonds. Subject to the discussions below under the headings "Information Reporting and Backup Withholding" and "Foreign Account Tax Compliance," any gain realized by a Non-U.S. Holder upon the sale, exchange, redemption, retirement (including pursuant to an offer by Allina Health) or other disposition of a Bond generally will not be subject to U.S. federal income tax, unless (1) such gain is effectively connected with the conduct by such Non-U.S. Holder of a trade or business within the United States or (2) in the case of any gain realized by an individual Non-U.S. Holder, such holder is present in the United States for 183 days or more in the taxable year of such disposition and certain other conditions are met.

Information Reporting and Backup Withholding. Payments of principal and interest on any Bonds to a holder that is not a United States person will not be subject to any backup withholding tax requirements if the beneficial owner of the Bond or a financial institution holding the Bond on behalf of the beneficial owner in the ordinary course of its trade or business provides an appropriate certification to the payer and the payer does not have actual knowledge that the certification is false. If a beneficial owner provides the certification, the certification must give the name and address of such owner, state that such owner is not a United States person, or, in the case of an individual, that such owner is neither a citizen nor a resident of the United States, and the owner must sign the certificate under penalties of perjury.

Foreign Account Tax Compliance

Sections 1471 through 1474 of the Code (commonly referred to as "FATCA") impose a new reporting regime and potentially a 30% withholding tax on certain payments made to or through (i) a "foreign financial institution" (as specifically defined in the Code) that does not enter into an agreement with the IRS to provide the IRS with certain information in respect of its account holders and investors or (ii) a "non-financial foreign entity" (as specifically defined in the Code) that does not provide sufficient information with respect to its substantial U.S. owners, if any. The United States has entered into, and continues to negotiate, intergovernmental agreements (each, an "IGA") with a number of other jurisdictions to facilitate the implementation of FATCA. An IGA may significantly alter the application of FATCA and its information reporting and withholding requirements with respect to any particular investor.

FATCA withholding may apply to payments of interest (including OID) on the Bonds and, in the case of a sale or other disposition of Bonds after December 31, 2016, the gross proceeds of such disposition if the payee does not provide documentation (typically IRS Form W-9 or the relevant IRS Form W-8) providing the required information or establishing compliance with, or an exemption from, FATCA. FATCA is particularly complex, and its application remains uncertain. Prospective investors should consult their own tax advisors regarding how these rules may apply in their particular circumstances.

The foregoing summary is included herein for general information only and does not discuss all aspects of U.S. federal taxation that may be relevant to a particular holder of Bonds in light of the holder's particular circumstances and income tax situation. Prospective investors are urged to consult their own tax advisors as to any tax consequences to them from the purchase, ownership and disposition of the Bonds, including the application and effect of state, local, non-U.S., and other tax laws.

Effect of Defeasance

Defeasance of any of the Bonds may result in a reissuance thereof, in which event the Holder will recognize taxable gain or loss equal to the difference between the amount realized from the sale, exchange or retirement (less any accrued qualified stated interest which will be taxable as such) and the Holder's adjusted tax basis in the Bonds.

CERTAIN ERISA CONSIDERATIONS

The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), imposes certain restrictions on employee pension and welfare benefit plans subject to ERISA ("ERISA Plans") regarding prohibited transactions, and also imposes certain obligations on those persons who are fiduciaries with respect to ERISA Plans. Section 4975 of the Code imposes similar prohibited transaction restrictions on (i) tax-qualified retirement plans described in Section 401(a) and 403(a) of the Code, which are exempt from tax under section 501(a) of the Code and which are not governmental and church plans as defined herein ("Qualified Retirement Plans"), and (ii) Individual Retirement Accounts described in Section 408(b) of the Code ("Tax-Favored Plans"). Certain employee benefit plans, such as governmental plans (as defined in Section 3(32) of ERISA), and, if no election has been made under Section 410(d) of the Code, church plans (as defined in Section 3(33) of ERISA), are not subject to ERISA requirements. Additionally, such governmental and non-electing church plans are not subject to the requirements of Section 4975 of the Code. Although assets of such governmental or non-electing church plans may be invested in the Bonds without regard to the ERISA and Code considerations described below, any such investment may be subject to provisions of applicable federal and state law that are, to a material extent, similar to the requirements of ERISA and Section 4975 of the Code ("Similar Law").

In addition to the imposition of general fiduciary obligations, including those of investment prudence and diversification and the requirement that a plan's investment be made in accordance with the documents governing the plan, Section 406 of ERISA and Section 4975 of the Code prohibit a broad range of transactions involving assets of ERISA Plans and Tax-Favored Plans and entities whose underlying assets include plan assets by reason of ERISA Plans or Tax-Favored Plans investing in such entities (collectively, "Benefit Plans") and persons who have certain specified relationships to the Benefit Plans (such persons are referred to as "Parties in Interest" or "Disqualified Persons"), unless a statutory or administrative exemption is available. Certain Parties in Interest (or Disqualified Persons) that participate in a prohibited transaction may be subject to a penalty (or an excise tax) imposed pursuant to Section 502(i) of ERISA (or Section 4975 of the Code) unless a statutory or administrative exemption is available.

Certain transactions involving the purchase, holding or transfer of the Bonds might be deemed to constitute prohibited transactions under ERISA and the Code if assets of Allina Health were deemed to be assets of a Benefit Plan. Under final regulations issued by the United States Department of Labor (the "Plan Assets Regulation"), the assets of Allina Health would be treated as plan assets of a Benefit Plan for the purposes of ERISA and the Code if the Benefit Plan acquires an "equity interest" in Allina Health and none of the exceptions contained in the Plan Assets Regulation is applicable. An equity interest is defined under the Plan Assets Regulation as an interest in an entity other than an instrument which is treated as indebtedness under applicable local law and which has no substantial equity features. Although there can be no assurances in this regard, it appears that the Bonds should be treated as debt without substantial equity features for purposes of the Plan Assets Regulation. However, without regard to whether the Bonds are treated as an equity interest for such purposes, the acquisition or holding of Bonds by or on behalf of a Benefit Plan could be considered to give rise to a prohibited transaction if Allina Health, the Obligated Group Members, the Master Trustee or the Bond Trustee, or any of their respective affiliates, is or becomes a Party in Interest or a Disqualified Person with respect to such Benefit Plan. The fiduciary of a Benefit Plan that proposes to purchase and hold any Bonds should consider, among other things, whether such purchase and holding may involve (i) the direct or indirect extension of credit to a Party in Interest, (ii) the sale or exchange or any property between a Benefit Plan and a Party in Interest, and (iii) the transfer to, or use by or for the benefit of, a Party in Interest, of any Benefit Plan assets.

Certain exemptions from the prohibited transaction rules could be applicable depending on the type and circumstances of the plan fiduciary making the decision to acquire a Bond. Included among these exemptions are: Prohibited Transaction Class Exemption ("PTCE") 75-1, relating to certain broker-dealer transactions, PTCE 96-23,

regarding transactions effected by "in-house asset managers"; PTCE 90-1, regarding investments by insurance company pooled separate accounts; PTCE 95-60, regarding transactions effected by "insurance company general accounts"; PTCE 91-38, regarding investments by bank collective investment funds; and PTCE 84-14, regarding transactions effected by "qualified professional asset managers." In addition, Section 408(b)(17) of ERISA and Section 4975(d)(20) of the Code generally provide for a statutory exemption from the prohibitions of Section 406(a) of ERISA and Section 4975 of the Code for certain transactions between Benefit Plans and persons who are Parties in Interest solely by reason of providing services to such Benefit Plans or who are persons affiliated with such service providers, provided generally that such persons are not fiduciaries with respect to "plan assets" of any Benefit Plan involved in the transaction and that certain other conditions are satisfied.

By its acceptance of a Bond, each purchaser will be deemed to have represented and warranted that either (i) no "plan assets" of any Plan have been used to purchase such Bond, or (ii) each Underwriter is not a Party in Interest with respect to the "plan assets" of any Plan used to purchase such Bond, or (iii) the purchase and holding of such Bonds is exempt from the prohibited transaction restrictions of ERISA and Section 4975 of the Code pursuant to a statutory exemption or an administrative class exemption.

Any Benefit Plan fiduciary considering whether to purchase Bonds on behalf of an ERISA Plan should consult with its counsel regarding the applicability of the fiduciary responsibility and prohibited transaction provisions of ERISA and the Code to such investment and the availability of any of the exemptions referred to above. In addition, persons responsible for considering the purchase of Bonds by a governmental plan or non-electing church plan should consult with its counsel regarding the applicability of any Similar Law to such an investment.

INDEPENDENT AUDITORS

The consolidated financial statements of Allina Health System as of December 31, 2014, 2013 and 2012, and for the years then ended, included in APPENDIX B, have been audited by KPMG LLP, independent auditors, as stated in their report included in APPENDIX B.

LEGAL MATTERS

The validity of the Bonds and certain other legal matters are subject to the approving opinion of counsel to Allina Health, Dorsey & Whitney LLP, Minneapolis, Minnesota. Certain legal matters will be passed upon for the Underwriters by their counsel, Orrick, Herrington & Sutcliffe LLP.

MISCELLANEOUS

The summaries and descriptions herein and incorporated herein of the Bond Indenture, the Series 2015 Obligation, the Master Indenture, the Continuing Disclosure Undertaking and any other documents relating to the Bonds and not purporting to be quoted in full are qualified in their entirety by reference to the complete provisions of such documents, copies of which may be obtained from Allina Health and the Underwriters during the period of the offering and from the Bond Trustee or Master Trustee, as applicable, thereafter.

The distribution of this Offering Memorandum by Allina Health has been duly authorized by Allina Health. This Offering Memorandum is not to be construed as a contract or agreement between Allina Health and the purchasers or Holders of any of the Bonds.

ALLINA HEALTH SYSTEM

By: /s/Duncan Gallagher
Executive Vice President,
Chief Administrative Officer and
Chief Financial Officer

APPENDIX A

ALLINA HEALTH SYSTEM

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INTRODUCTION

Allina Health System ("Allina Health") is a Minnesota nonprofit corporation that delivers health care services to patients in Minnesota and western Wisconsin. As a mission-driven organization, Allina Health is committed to improving the health of the communities it serves. With approximately 25,000 full- and part-time employees, Allina Health is one of the largest employers in Minnesota. Allina Health consolidated revenue for the year ended December 31, 2014 was $3.6 billion. As an integrated health system that includes hospitals; over 1,310 employed physicians; emergency, ambulatory; homecare and hospice services; and an automated electronic medical record system, Allina Health is positioned as a leader in healthcare in the Minneapolis-St. Paul (the "Twin Cities") area and is well-positioned for health care reform.

Mission Focus

Integration among payers, hospitals and physician groups in the Minneapolis-St. Paul metropolitan area has created a complex marketplace of interrelated entities. Within this business environment, organizations both compete and serve as vendors and customers of one another. While participating in this competitive atmosphere, Allina Health is committed to focus on its core mission:

"We serve our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care."

Several Allina Health goals and initiatives are designed to deliver unparalleled quality and markedly enhance the patient care experience at Allina Health. Through constant attention to its core mission and its values of integrity, respect, trust, compassion and stewardship, Allina Health strives to be known and trusted in its communities as the place where patients choose to receive care, employees choose to work and physicians choose to practice. Allina Health management believes that by striving to provide exceptional quality of care and to furnish an efficient, attractive work environment for hospital and clinic staff and physicians, it will continue to experience market share increases. Management believes that these efforts will also secure the organization's place as a preferred provider of health care services for patients, their families, employees and third-party payers.

STRATEGY

Allina Health's strategy is focused on advancing four key goals:

(1) Providing optimal health, well-being and experience for individuals;
(2) Providing optimal health and well-being for the communities Allina Health serves;
(3) Providing affordable care for all; and
(4) Maintaining and advancing organizational vitality.

Optimal health, well-being and experience for individuals

Allina Health is working to achieve optimal health, well-being and experience for individuals through the development of an integrated, relationship-based care model that connects expert care across the continuum and provides care in the most convenient, appropriate settings. Allina Health strives to do this through:

- a focus on building strong relationships between patients and their Allina Health primary care provider
- using consumer insights to drive integrated digital care delivery and transaction models
- advancing integrative "whole person" approaches to care

Broadening its relationships with Allina Health members is critical to this strategy. Allina Health's aim is to provide exceptional experiences founded on consistent, connected, coordinated and convenient care. Connected care runs across the continuum and includes specialty and primary care integration; providing strong care navigation and support services and building care continuum partnerships with sub-acute providers. Providing

expert care in convenient settings includes the expansion of outpatient specialty hubs and deliberative positioning of Allina Health's inpatient hospital assets. Allina Health is making significant investments in its primary care infrastructure to enable its primary care physicians to spend more time with their patients and develop relationships that will foster better care and improved long-term health.

Optimal health and well-being for the communities Allina Health serves

Improving community health and well-being is founded on investment in primary prevention capabilities and working with Allina Health's communities to better understand and provide care sensitive to social determinants which affect care access. Allina Health is working collaboratively, and in a targeted manner, with its communities to identify community members with medical and social complexities and to improve the health status of those in greatest need. Allina Health's goal is to provide the best possible care to all members of the communities Allina Health serves.

These strategies are enabled by data-driven best practices spread through the Allina Health Integrated Medical Network. The Allina Integrated Medical Network consists of 3,000 physician members, including both providers employed by Allina Health and independent physicians who provide care at Allina Health's facilities. Through this integrated clinical network, Allina Health works to leverage data to improve its care model and ensure best practices are used consistently across its sites of care. Allina Health's partnership with Health Catalyst (described in "Recent Initiatives and Developments") enables Allina Health to collect, mine, analyze and interpret data more effectively and Allina Health's investment in clinical service lines helps foster consistent use of best practices.

Affordable care for all

Allina Health seeks to make care more affordable by accelerating the industry's shift to outcomes-based payments. Allina Health believes the acceleration can disrupt the market in a productive way for consumers, employers and governments. That said, Allina Health strives to be prudent in seeking contracting opportunities to advance its learnings while positioning the care system for successful performance in population health payment mechanisms as well as value-based reimbursement mechanisms.

Allina Health believes promoting the Allina Health brand value story and investing in brand building will create consumer and purchaser affinity for the Allina Health brand. Advancing the brand will be critical as care and insurance purchasing decisions are increasingly made on an individual consumer level facilitated by public and private exchanges. Management of Allina Health is confident it can competitively position Allina Health narrow network products in the exchange markets. In this evolving market, Allina Health's goal is to stimulate member growth and diversify its revenue base.

Organizational vitality

Finally, organizational vitality is critical to advancing Allina Health's strategies and investing in the care model and financing transitions it envisions. To that end significant management attention is dedicated to annual performance enhancement initiatives to sustain Allina Health's operating results in an environment impacted by rate pressure from the governments as well as insurers.

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MEMBERS OF ALLINA HEALTH

Obligated Group

The Allina Health Obligated Group ("Obligated Group") was created under the Master Trust Indenture dated as of October 1, 1998, between Allina Health and Wells Fargo Bank, National Association, as successor master trustee (the "Master Indenture"). Entities in the Obligated Group are shown in the chart on the following page. Currently, Allina Health is the only member of the Obligated Group and the Credit Group. Allina Health directly owns and operates its acute care hospitals, ambulatory care centers and clinics, with the exception of St. Francis Regional Medical Center, in Shakopee, Minnesota ("St. Francis"), which is operated by Allina Health but jointly owned with Essentia Health Critical Access Group and HealthPartners. See "SECURITY FOR THE BONDS – The Master Indenture and the Security Agreement" in the front portion of this Offering Memorandum for a description of the Master Indenture, the Obligated Group and the Credit Group.

Subsidiaries and Affiliates outside the Obligated Group

Allina Health owns and operates a number of wholly owned direct and indirect subsidiaries outside of the Obligated Group. In aggregate, these subsidiaries represented approximately $48 million or 1.3% of Allina Health's consolidated total operating revenue, -2.0% of net income, and 3.5% of unrestricted net assets for the year ended December 31, 2014. Allina Health contributes capital to certain subsidiaries, if needed. A net capital contribution to subsidiaries was not needed in the year ended December 31, 2014. The net capital contributions to subsidiaries in the year ended December 31, 2013 and 2012 was $14.7 million and $35.2 million, respectively. The decreases in capital contributions to subsidiaries are due to changes in subsidiaries and the Obligated Group. Aspen and Quello clinics, formerly wholly-owned subsidiaries of Allina Health, are now owned and operated by Allina Health, and Regina Hospital, formerly a wholly-owned subsidiary of Allina Health merged into Allina Health effective December 31, 2013.

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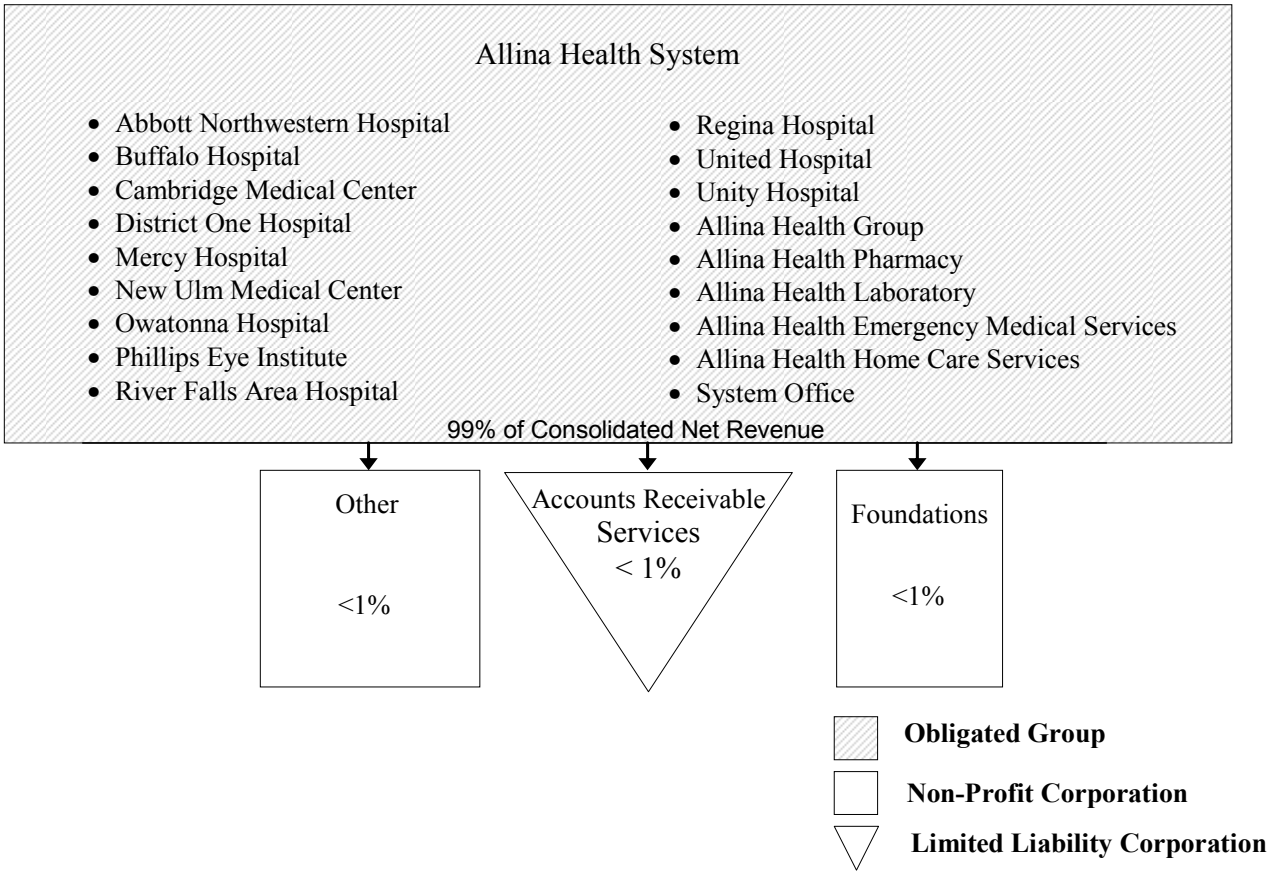
ORGANIZATIONAL CHART

The organizational structure of Allina Health is illustrated below. Allina Health directly owns and operates its acute care hospitals (with the exception of St. Francis, which is operated by Allina Health but jointly owned with Essentia Health Critical Access Group and HealthPartners), ambulatory care centers and clinics, which are all operated as separate divisions within Allina Health. In addition to the relationships documented, Allina Health holds interests in several smaller subsidiary corporations, limited liability companies, joint ventures and partnerships that have been excluded from the chart below because they collectively comprise less than one percent of net revenue.



Location of Care Delivery Sites

The following map shows the locations of Allina Health owned (with the exception of St. Francis) and operated hospitals and clinics.

FACILITIES AND OPERATIONS

Hospitals

The hospitals owned (with the exception of St. Francis) and operated by Allina Health and their locations are described in the following table and shown on the map on page A-5.

Acute Care Hospitals		As of June 30, 2015	
Hospital Name	**Location**	**Licensed Beds[(1)]**	**Staffed Beds**
Metropolitan Hospitals			
Abbott Northwestern Hospital	Minneapolis, MN	952	631
United Hospital	Saint Paul, MN	546	382
Mercy Hospital	Coon Rapids, MN	271	253
Unity Hospital	Fridley, MN	275	175
Phillips Eye Institute	Minneapolis, MN	20	8
Total Metropolitan Hospitals		2,064	1,449
Regional Hospitals			
Buffalo Hospital	Buffalo, MN	65	32
Cambridge Medical Center	Cambridge, MN	86	75
District One Hospital	Faribault, MN	49	41
New Ulm Medical Center	New Ulm, MN	62	35
Owatonna Hospital	Owatonna, MN	43	43
Regina Hospital	Hastings, MN	57	47
River Falls Area Hospital	River Falls, WI	25	6
Total Regional Hospitals		387	279
Total – Allina Health owned and operated		2,451	1,728
St. Francis Regional Medical Center	Shakopee, MN	93	53
Total – All Hospitals		2,544	1,781

(1) Not including licensed bassinets.

STATISTICAL INFORMATION

Consolidated Utilization Table

The following table reflects consolidated Allina Health utilization statistics for the three years ended December 31, 2014 and the six months ended June 30, 2015 and 2014.

	Six Months Ended June 30,		Years Ended December 31,		
Utilization Statistics	2015	2014	2014	2013	2012
Clinics					
Work RVUs*	3,497,492	3,258,419	6,662,869	6,370,479	6,128,533
Providers (FTEs)	1,131	1,162	1,184	1,086	1,046
Hospitals					
Admissions	51,510	51,412	102,748	106,509	107,701
Patient Days	210,621	209,641	418,567	422,403	429,270
Average Length of Stay *(days)*	4.1	4.1	4.1	4.0	4.0
Total Staffed Beds	1,728	1,736	1,692	1,753	1,716
Outpatient Registrations	648,386	601,753	1,231,449	1,163,353	1,154,798
Emergency Room Visits	156,172	143,445	298,543	282,860	273,817
Inpatient Surgical Procedures	14,856	14,745	29,861	31,059	32,442
Outpatient Surgical Procedures	28,462	30,196	61,938	61,403	54,431

* RVU = Relative Value Unit is a measure of relative resource utilization. Relative value units are used in cost accounting to allocate costs within an area to the chargeable activity.

Metropolitan Hospitals

The following is a description of the metropolitan area acute care hospitals owned and operated by Allina Health.

Abbott Northwestern Hospital

Abbott Northwestern Hospital ("ANW") is an acute care hospital licensed to operate 952 beds located on a 14-acre campus two miles southeast of downtown Minneapolis. As of June 30, 2015, ANW staffed 631 beds for inpatient services and its medical staff included 1,356 members. ANW provides a full range of inpatient and outpatient acute care services for medical, surgical, mental health and obstetric patients, including specialized units for coronary care, open heart surgery, neuroaugmentive surgery, medical and surgical intensive care, high-risk maternity care, acute psychiatric care, chemical dependency, oncology, comprehensive epilepsy treatment and rehabilitation services.

United Hospital

United Hospital ("United") is an acute care hospital licensed for 546 beds located in downtown St. Paul. As of June 30, 2015, United staffed 382 beds for inpatient services and its medical staff consisted of 1,378 members. United provides a full range of inpatient and outpatient acute care services for medical, surgical, obstetric, and psychiatric patients. Specialized units have been developed for cardiac care, medical and surgical intensive care, high-risk maternity care, acute psychiatric care, oncology, epilepsy treatment and physical rehabilitation.

Mercy Hospital

Mercy Hospital ("Mercy") is an acute care hospital licensed for 271 beds located in the City of Coon Rapids in Anoka County, Minnesota. As of June 30, 2015, Mercy staffed 253 beds for inpatient services and its medical staff included 867 members. Mercy offers a range of primary and specialty care services, including oncology; cardiology; cardiac surgery; orthopedics; neurology; gynecology and obstetrics; and behavioral health services.

Unity Hospital

Unity Hospital ("Unity") is an acute care hospital licensed for 275 beds located in the City of Fridley in Anoka County, Minnesota. As of June 30, 2015, Unity staffed 175 beds staffed for inpatient services and its medical staff included 568 members. Unity offers a range of primary and specialty care services, including bariatrics, cardiology, geriatric health services, and behavioral health services.

Phillip Eye Institute

Phillip Eye Institute ("PEI") is the one of the largest eye specialty hospitals in the nation, and it completes approximately 11,500 eye surgery cases in a highly specialized setting. PEI is a community resource utilized by virtually all independent and competing ophthalmology systems because of the unique, specialized care provided. In addition, approximately 20 optometry clinics exist in Allina Health clinics, thus providing a highly integrated, complete continuum eye care service line. In addition, the Kirby Puckett Eye Mobile supports the mission of Allina Health by providing free eye exams and glasses to children who would otherwise not receive optimal eye care.

Regional Hospitals

Allina Health owns and operates eight other hospitals, seven in Minnesota and one in Wisconsin. These eight facilities deliver primary and specialty health care services in communities outside of Minneapolis-St. Paul and also generate tertiary care admissions from these communities to the metropolitan hospitals of Allina Health. The eight hospitals are: 1) Buffalo Hospital in Buffalo; 2) Cambridge Medical Center in Cambridge; 3) District One Hospital in Faribault; 4) New Ulm Medical Center in New Ulm; 5) Owatonna Hospital in Owatonna; 6) Regina Hospital in Hastings; 7) River Falls Area Hospital in River Falls, Wisconsin; and 8) St. Francis in Shakopee. New Ulm and River Falls are designated as "critical access" hospitals.

Allina Health is a 43.9% member in St. Francis, but exercises significant management control and is responsible for day-to-day operations through a Joint Membership Agreement. In October 2004, St. Francis issued debt as a stand-alone entity, which was re-financed in June 2014 and is recorded on St. Francis' financial statements. In addition, Allina Health and the joint members (Essentia Health Critical Access Group and HealthPartners) are guarantors of the 1987 debt for St. Francis, with Allina Health's portion of the guaranty being approximately $462,000.

Together, these regional hospitals are licensed for 480 beds of which 332 were staffed as of June 30, 2015. These hospitals have approximately 880 physicians on their separate medical staffs.

Clinical Service Lines

Primary Care Service Line/ Allina Health Clinics Division

The Allina Health Clinics Division consists of 64 clinics throughout Minnesota and Wisconsin. As a division, the goal is to build on the complementary strengths of each entity by combining administrative functions and integrating the vast array of clinic locations and mix of primary and specialty providers and services. Using the same electronic medical record system enables the division to share best practices for improving care and safety for all of its patients.

The following table indicates the size distribution of the medical staffs of the various Allina Health Clinics Division sites. The clinic locations are also noted on the map on page A-5.

NUMBER OF CLINICS EMPLOYING:			
1-5 Physicians	6-10 Physicians	11-15 Physicians	16+ Physicians
21	16	12	15

The Allina Health Clinics Division is an integral part of Allina Health's strategy for delivering health care services to patients in the Minneapolis-St. Paul metropolitan area and elsewhere in Minnesota and Wisconsin. Allina Health Clinics Division sites serve as the first point of contact with Allina Health's hospitals in a significant number of cases, contributing approximately 35% of inpatient admissions across Allina Health in 2014. In addition, Allina Health Clinics Division performs significant mission-related services for patients, providing greater levels of indigent care, services for Medicaid patients, care for AIDS patients and community education than would be typical for an independent, for-profit clinic.

Mother Baby Clinical Service Line

The Mother Baby Clinical Service Line works to provide excellent care, outcomes and experiences for mothers, babies, and families. The Mother Baby Clinical Service Line integrates mother and baby care across all 13 Allina Health delivery hospitals, all Minnesota perinatal locations, and Children's Hospitals and Clinics of Minnesota's Minneapolis and St. Paul campuses, encompassing care related to perinatology, obstetrics, newborns, and neonatology

Virginia Piper Cancer Institute ("VPCI") Oncology Service Line

The oncology service line creates an integrated network of multidisciplinary systems designed to deliver optimal cancer care to every Allina Health oncology patient. The service line is designed to provide the highest value cancer care across the cancer continuum, such as prevention, treatment and end of life planning. The oncology service line is one of Allina Health's most established service lines with demonstrated expertise establishing "best practices" via nine different program committees. Since cancer care is often best provided near the home of the patient, the oncology service line also helps to ensure the Allina Health brand is established across a wide geographic range. The research, publications, and clinical trials conducted through the oncology service line serve to position VPCI and Allina Health as industry leaders.

Surgical & Procedural Service Line

The Surgical and Procedural service line is the newest service line at Allina Health, and is designed to unite various specialties through a unified leadership structure. General Surgery, Bariatrics and Medical Weight Loss, Otolaryngology, Dermatology, Gastroenterology, Pulmonology and Sleep Medicine, Urology, and Plastic Surgery all participate in the new service line, and the service line establishes "best practice" standards for condition-specific care (e.g. sleep apnea) and ensures provision of comprehensive care in all of the specialties. The Surgical and Procedural Services line fundamentally supports the care patients receive at hospitals due to the surgical nature, but they also support outpatient care where appropriate.

Penny George™ Institute for Health and Healing

The Penny George Institute for Health and Healing (the "Penny George Institute") works to improve the health and wellness of the patients and communities that Allina Health serves. As the largest integrative health center embedded in a health system in the United States, the Penny George Institute uses a holistic approach that focuses on the mind, body and spirit. It has helped tens of thousands of individuals on their path to health or healing through its outpatient clinics, fitness center, programs for hospitalized patients, holistic education training programs for health professionals, and community initiatives. Services—ranging from integrative medicine

consultations with a physician to acupuncture to healthy lifestyle programs—are used for an array of reasons, such as supporting cancer treatments, managing chronic pain or simply improving one's overall health.

Neuroscience and Spine Service Line

The John Nasseff Neuroscience Institute (the "Neuroscience Institute") is the leading center for neurological and spine care in the Twin Cities and Upper Midwest. Each year, the Institute performs more than 2,000 major neurological surgeries, 1,000 neuro interventional procedures and 2,600 spine surgeries. The Neuroscience Institute also treats patients for neurological conditions such as stroke, tumors of the brain and spinal cord, epilepsy, Alzheimer's disease, balance and movement disorders, headaches, sleep disorders, chronic and acute pain and non-operative spine conditions. Advanced technology is combined with specialized physicians and staff, dedicated facilities and focused programs to make the Neuroscience Institute a comprehensive resource for neurological care and information. Recent technological enhancements include: Intraoperative MRI Suite (iMRI), Cyberknife and Varian Trilogy.

Orthopedics

The Allina Health Orthopedic Institute (the "Orthopedic Institute") is a new clinical service line, focused on delivering value for individuals, communities, and employers through caring for bone, muscle, joint, and sports related pain and other functional limitations. The Institute's goal is to improve quality of life for patients through enabling their participation in sports, arts, and other movement driven activities. There are over 50,000 orthopedic related visits across Allina Health yearly, with significant yearly growth. The orthopedics service line includes both employed and independent partners, and focuses on management of osteoarthritis, osteoporosis, freedom of movement and use for critical smaller extremities (hand, foot and ankle), and other acute, chronic, and inflammatory bone and joint related conditions. The Orthopedic Institute's goal is to emphasize preventive and non-surgical based care, enable surgical interventions by the highest quality of subspecialized providers, and by offering care that enables patients return to home and work.

Mental Health

Allina Health has a long and proud history of providing mental health and substance abuse care to its communities. Allina Health Mental Health exists today as the largest provider of mental health services in the Twin Cities metro area, with over 35 primary care clinics, three specialty care clinics and eight hospitals. Over a hundred Mental Health providers care for more than 100,000 patients per year, whose services range from hospital inpatient, partial hospitalization, assessment and referral, day treatment, substance abuse, clinic visits, and telemedicine.

Cardiovascular

The Allina Health Cardiovascular Service Line is a leading provider of heart and vascular care with national Centers of Excellence in cardiology, cardiovascular imaging, interventional cardiology and cardiothoracic surgery which address the full range of cardiovascular needs. Allina Health's cardiovascular regional system of care in 55 sites within a 5 state area allows for many of its patients to receive the majority of their care close to home. TeleHeart and Curbside Cardiology are examples of bringing our non-cardiology providers and patients quick access to cardiovascular services in their communities. Allina Health has a strong commitment to research and education. In 2014, over 120 peer-reviewed manuscripts and 150 local, regional, national and international presentations were given to patients and providers. Additionally, fellowships in cardiology in cardiovascular disease and cardiovascular subspecialties are offered within the Cardiovascular Service Line.

Courage Kenny Rehabilitation Institute

The Courage Kenny Rehabilitation Institute was created in 2013 by the merger of Courage Center and Sister Kenny Rehabilitation Institute. Today, the combined Courage Kenny Rehabilitation Institute's care team provides physician, nursing, therapy, community and mental health services in more than 40 locations in Minnesota and western Wisconsin, includes over 1,500 team members and 2,500 volunteers. Allina Health's community

services give patients and clients the opportunity to focus on improving their health and independence after they have completed more traditional rehabilitation programs.

Specialty Operations within Allina Health

Other specialty operations include the following Allina Health divisions:

Allina Health Home and Community Services

The Allina Health Home and Community Services houses services designed to maintain continuity of care for Allina Health's patients. These services include Home Care, Hospice & Palliative Care, Allina Health Home Oxygen & Medical Equipment, and SeniorCare Transitions. The services are detailed below:

Allina Health Home Care, Hospice & Palliative Care

Allina Health Home Care, Hospice & Palliative Care provides comfort, support, and compassionate care for patients with advanced illness or at the end of life and the loved ones caring for them.

- Home care provides a wide range of health care services for patients in their homes. Services are provided on an intermittent basis to patients with health care problems.

- Hospice care is for anyone with a life-limiting illness and whose life expectancy is determined to be six months or less if the disease runs its natural course.

- Palliative care is available to anyone who is in any stage of a chronic or advanced illness. In particular, it is for patients who are being treated for cancer or other serious diseases.

Allina Health Home Oxygen & Medical Equipment

Allina Health Home Oxygen & Medical Equipment ("HOME") has provided oxygen, medical equipment and supplies to Minnesota communities for over 20 years. A full service provider, carrying a wide array of medical equipment, HOME serves clients from pediatrics to geriatrics with varying needs. Services include oxygen and respiratory equipment, rehabilitation and mobility equipment, specialty beds as well as other equipment, supplies and services.

SeniorCare Transitions

SeniorCare Transitions provides primary care by geriatric nurse practitioners and physicians at more than 16 transitional care units and 50 nursing homes in the Twin Cities metropolitan area. They work with patients and their families to provide routine care, manage medical problems and monitor rehabilitation and plan for discharge.

Allina Health Emergency Medical Services

Allina Health Emergency Medical Services ("AHEMS") is one of the region's largest providers of emergency and non-emergency medical transportation employing approximately 400 individuals. AHEMS provides emergency ambulance service under licenses issued by the State of Minnesota serving over 80 communities with a combined population of one million throughout Minnesota. Non-emergency medical transportation includes stretcher and wheelchair transportation of patients to and from Allina Health. These services are supported by state-of-the-art dispatch, business office, vehicle maintenance, and clinical support functions.

Allina Health Pharmacy

Allina Health Pharmacy ("AHP") fills orders online and at 16 locations in the Twin Cities and surrounding communities. AHP stocks many special-needs medications. Pharmacy team members have special expertise in many acute and chronic medication needs, including organ transplant, diabetes, infertility, pediatrics, oncology and management of multiple medications.

Allina Health Laboratory

Allina Health Laboratory ("AHL") is an integrated, multi-site laboratory service, providing service throughout Allina Health. AHL partners with Hospital Pathology Associates, P.A., which is not affiliated with Allina Health and includes 30 certified pathologists in a variety of specialties.

Joint Ventures

Allina Health has financial interests in several joint ventures with other organizations, including ambulatory care services. Allina Health's ownership interest in ambulatory care joint ventures ranges from 50% to 80%. The ambulatory surgical center joint ventures are located in Plymouth, Woodbury, and Edina, Minnesota. None of these joint ventures represents a significant contribution to Allina Health's revenue stream or overall operations, with the exception of St. Francis Regional Medical Center, which was discussed previously.

Relationships with Physicians

Both employed and non-employed medical staff members are critical to the success of Allina Health's hospitals. Employed physicians and independent physicians all enjoy equal status on the medical staff of Allina Health hospitals. Medical staff leadership is provided by both employed and non-employed physicians. The clinic division enjoys a favorable relationship with many of the independent specialist groups, which receive specialty referrals from the clinic division's primary care physicians.

As of December 31, 2014, Allina Health employed approximately 1,310 physicians including approximately 750 primary care physicians who account for over 35% of the inpatient admissions at Allina Health hospitals.

Allina Health Specialty Associates, Inc. ("ASA"), operating under the name Minneapolis Heart Institute®, employs approximately 75 physicians specializing in cardiovascular disease, thoracic surgery and vascular surgery. ASA employed physicians accounted for approximately 15% of the inpatient admissions at Abbott Northwestern Hospital in 2014. In addition, Allina Health directly employs approximately 485 physicians in specialty-related groups at its hospitals, including perinatologists, hospitalists and internists providing resident education at Abbott Northwestern Hospital and United Hospital.

Allina Health seeks to engage physicians in its operations and to avoid conflicts by encouraging physician participation at all levels of the organization: on the Allina Health Board, the Physician Governance Committee (a standing committee of the Allina Health Board), and the Clinical Leadership Team and through a variety of clinical task forces and other specialized initiatives.

AIM Network

The Allina Health Integrated Medical ("AIM") Network aligns Allina Health physicians, 1,730 independent medical physicians, and over 20 hospitals to deliver quality and efficiency in patient care. The AIM Network is structured to contract with third party payers under outcomes based payment arrangements. The AIM Network is organized to provide a narrowed network of Allina Health aligned providers to share quality and cost performance risk. The AIM Network has developed a set of specialty performance measures and data sharing mechanisms to enhance its performance under outcomes based payment arrangements.

FINANCIAL INFORMATION

Comparative Financial Statements

The following consolidated balance sheets as of December 31, 2014, 2013, 2012 and June 30, 2015 and consolidated statements of operations and changes in net assets for the years ended December 31, 2014, 2013, 2012, and the six-months ended June 30, 2015 and 2014 have been prepared by Allina Health.

The consolidated balance sheets as of December 31, 2014, 2013 and 2012, and consolidated statements of operations and changes in net assets for Allina Health for the years ended December 31, 2014, 2013, and 2012, have been derived from the audited consolidated financial statements of Allina Health. This financial information should be read in conjunction with the audited financial statements of Allina Health included as APPENDIX B to this Offering Memorandum.

The consolidated balance sheet as of June 30, 2015 and the consolidated statements of operations and changes in net assets for Allina Health for the six months ended June 30, 2015 and 2014, are derived from financial statements prepared by management and include all adjustments considered necessary for a fair representation of the results of operations for such interim periods. This information should not be considered to be indicative of the results for the year ending December 31, 2015 or any period thereafter.

The consolidated financial statements of Allina Health include the Obligated Group and entities that are not members of the Obligated Group. In aggregate, these non-Obligated Group members represented approximately $48 million or 1.3% of Allina Health's consolidated total operating revenue, -2.0% of net income, and 3.5% of unrestricted net assets for the year ended December 31, 2014.

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ALLINA HEALTH SYSTEM
CONSOLIDATED BALANCE SHEETS
($ Thousands)

	June 30, 2015	December 31, 2014	December 31, 2013	December 31, 2012
Assets	(unaudited)			
Current assets:				
Cash and cash equivalents	$ 167,100	$ 180,985	$ 132,704	$ 147,405
Short-term investments	346,434	357,511	315,058	341,033
Patient accounts receivable, net	448,987	419,522	405,095	385,761
Inventories	57,805	55,311	53,146	53,088
Other current assets	112,502	109,389	75,126	60,469
	1,132,828	1,122,718	981,129	987,756
Long-term investments	1,194,362	1,180,534	1,123,312	955,921
Investments with limited uses	153,408	150,162	152,555	131,539
Land, buildings and equipment, net	1,091,113	1,041,950	1,050,770	956,776
Other assets	271,014	246,553	225,597	176,732
Total assets	$3,842,725	$3,741,917	$3,533,363	$3,208,724
Liabilities and net assets				
Current liabilities:				
Accounts payable and accrued expenses	$ 396,157	$ 428,185	$ 420,116	$ 391,905
Current portion – long-term debt	20,179	20,347	39,368	39,069
Other current liabilities	70,198	81,413	77,770	79,697
	486,534	529,945	537,254	510,671
Long-term debt	614,206	613,294	614,806	634,722
Other liabilities	417,233	420,545	369,909	426,093
Total liabilities	$1,517,973	$1,563,784	$1,521,969	$1,571,486
Net assets:				
Unrestricted	$2,150,215	$2,008,030	$1,857,436	$1,501,921
Temporarily restricted	119,423	115,155	98,925	89,536
Permanently restricted	55,114	54,948	55,033	45,781
Total net assets	2,324,752	2,178,133	2,011,394	1,637,238
Total liabilities and net assets	$3,842,725	$3,741,917	$3,533,363	$3,208,724

ALLINA HEALTH SYSTEM
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
($ Thousands)

	Six Months Ended June 30,		Years Ended December 31,		
	2015	2014	2014	2013	2012
Revenue	(unaudited)	(unaudited)			
Patient service revenue net of contractual adjustments	$1,788,142	$1,666,738	$3,465,733	$3,291,537	$3,173,116
Provision for bad debts	(50,552)	(47,526)	(93,547)	(90,581)	(76,201)
Net patient service revenue	1,737,590	1,619,212	3,372,186	3,200,956	3,096,915
Other operating revenue	136,779	98,217	231,495	219,609	181,458
Total revenues	1,874,369	1,717,429	3,603,681	3,420,565	3,278,373
Expenses					
Salaries and benefits	1,146,629	1,097,816	2,240,474	2,096,786	2,038,575
Supplies and services	411,494	374,812	787,580	758,210	721,793
Depreciation and amortization	74,859	73,030	147,844	138,145	132,564
Financing costs	12,036	12,247	24,392	24,591	25,989
State assessments and taxes	43,676	39,654	79,481	75,787	70,852
Utilities and maintenance	33,740	34,021	74,317	71,179	63,323
Other operating expenses	61,900	58,221	103,649	122,428	97,243
Total expenses	1,784,334	1,689,801	3,457,737	3,287,126	3,150,339
Operating income	90,035	27,628	145,944	133,439	128,034
Nonoperating:					
Investment return	13,104	56,158	46,990	92,983	88,713
Interest rate swap agreements	(2,793)	(21,903)	(42,800)	25,634	(13,029)
Contributions received in acquisitions	36,718	-	-	76,611	-
Other	(1,156)	(1,477)	(3,243)	(2,210)	(3,237)
Excess of revenues over expenses	$ 135,908	$ 60,406	$ 146,891	$ 326,457	$ 200,481

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ALLINA HEALTH SYSTEM
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (continued)
($ Thousands)

	Six Months Ended June 30,		Years Ended December 31,		
	2015	**2014**	**2014**	**2013**	**2012**
Unrestricted net assets over expenses	**(unaudited)**	**(unaudited)**			
Excess of revenue over expenses	$ 135,908	$ 60,406	$ 146,891	$ 326,457	$ 200,481
Net assets released from restrictions for capital purposes	2,404	1,205	7,080	18,469	7,260
Amortization of unrealized loss on interest rate swap agreement	437	437	874	874	874
Other	3,436	567	(4,251)	9,715	565
Increase in unrestricted net assets	142,185	62,615	150,594	355,515	209,180
Temporarily restricted net assets					
Contributions	10,990	17,899	31,884	18,982	27,312
Contribution received in acquisitions	-	-	-	12,188	-
Investment return	1,146	4,581	4,360	9,280	7,621
Net assets released from restrictions	(7,004)	(6,259)	(21,151)	(30,255)	(15,856)
Other	(864)	290	1,137	(806)	95
Increase in temporarily restricted net assets	4,268	16,511	16,230	9,389	19,172
Permanently restricted net assets					
Contributions for endowment funds	150	184	396	209	760
Contribution received in acquisitions	-	-	-	9,537	-
Investment return	16	69	34	106	80
Other	-	8	(515)	(600)	(1,215)
Increase (decrease) in permanently restricted net assets	166	261	(85)	9,252	(375)
Increase in net assets	146,619	79,387	166,739	374,156	227,977
Net assets at beginning of period	2,178,133	2,011,394	2,011,394	1,637,238	1,409,261
Net assets at end of period	**$2,324,752**	**$2,090,781**	**$2,178,133**	**$2,011,394**	**$1,637,238**

Uncompensated Care

Allina Health provides medical care without charge or at reduced cost to patients who live in the communities that it serves through the provision of charity care. Allina Health identifies patients that qualify for charity care based upon certain guidelines related to a patient's ability to pay for services. The Allina Health hospitals provide a discount on billed charges for medically necessary care delivered to patients who are uninsured, underinsured, and ineligible for government programs or otherwise medically indigent.

The schedule below reflects uncompensated care at gross charges forgone. The estimated cost of providing charity care, by applying a cost to charge ratio to charges identified as charity care, was $21.4 million, $29.5 million, and $30.4 million for the years ended December 31, 2014, 2013, and 2012, respectively. The estimated cost of providing charity care for the six months ended June 30, 2015 and 2014 were $8.5 million and $12.6 million, respectively.

Uncompensated Care at Gross Charges ($ Thousands)	For the Six Months Ended June 30,		For the Years Ended December 31,		
	2015	2014	2014	2013	2012
Uninsured Discount	$12,316	$17,784	$ 32,623	$ 46,500	$ 39,169
Charity Care Discount	20,521	30,005	50,623	74,083	80,384
Bad Debt Expense	50,552	47,526	93,547	90,581	76,201
Total Uncompensated Care	$83,390	$95,315	$176,793	$211,164	$195,755
Total Uncompensated Care as a % of Gross Patient Charges	2.0%	2.4%	2.2%	2.7%	2.4%

Net Patient Service Revenue

Allina Health has agreements with third-party payers who provide payments for health care services that are discounted from charges. During 2014 and 2013 and the six months ended June 30, 2015 and June 30, 2014, successful appeals and cost report settlements resulted in an increase in operating income of $39.7 million, $16.6 million, $2.8 million, and $2.0 million, respectively.

Managed Care Relationships

Allina Health negotiates and contracts with managed care payers through a centralized payer relations function. Managed care payers accounted for 55% of Allina Health's total net patient service revenue in 2014. Allina Health's top three managed care payers comprise 45.2% and all have contracts that expire in staggering years through December 31, 2016. Allina Health, separately and in conjunction with managed care payers, continues to redesign clinical processes and to develop evidenced-based guidelines in order to decrease costs and provide the demonstrable improvements in quality required by managed care.

The charts below show that payer mix has remained relatively stable.

Payer Mix (% of Net Patient Revenue)	For the Six Months Ended June 30,		For the Years Ended December 31,		
	2015	2014	2014	2013	2012
Medicare	29%	29%	29%	29%	28%
Medicaid	10	9	10	9	10
Managed Care	54	56	55	57	57
Commercial and Other	7	6	6	5	5
Total	100%	100%	100%	100%	100%

Net Operating Revenue

The following table sets forth the allocation of net operating revenue among Allina Health's hospitals, clinics and other operations for the year ended December 31, 2014:

Operating Unit	Percentage of Net Operating Revenue	Net Operating Revenue
Abbott Northwestern Hospital	29%	$1,058,672,383
Clinics	18%	648,540,688
United Hospital	14%	489,980,493
Mercy Hospital	11%	408,980,647
Regional Hospitals	12%	420,859,435
Specialty Care Operations	10%	348,048,198
Unity Hospital	5%	187,858,338
Other	1%	40,740,412
	100%	$3,603,680,594

Capitalization

The following table sets forth the actual capitalization of the Obligated Group as of December 31, 2014, and June 30, 2015 and the pro forma capitalization as of June 30, 2015, adjusted to reflect the issuance of the Bonds in the aggregate principal amount of $250,000,000.

Capitalization ($ Thousands)	Pro-forma June 30, 2015	June 30, 2015	December 31, 2014
Series 2015 Bonds	$ 250,000	-	-
Series 2009A Bonds	175,275	$ 175,275	$ 175,275
Series 2009BC Bonds	164,525	164,525	164,525
Series 2007A Bonds	105,415	105,415	105,415
Series 2007C Bonds	121,250	121,250	121,250
Series 1998A Bonds	14,575	14,575	14,575
Series 1993B Bonds	24,900	24,900	24,900
Series 2014 Note	20,165	20,165	20,165
All Other	5,205	5,205	4,216
Unamortized Portion of Original Issue Premium (Discount)	3,075	3,075	3,320
Total Alina Health System Long-term Debt	**$ 884,385**	**$ 634,385**	**$ 633,641**
Allina Health System			
Unrestricted Net Assets	$2,150,215	$2,150,215	$2,008,030
Total Consolidated Long-term Debt & Unrestricted Net Assets	$3,034,600	$2,784,600	$2,641,671
Debt to Capitalization Ratio	29.1%	22.8%	24.0%

Debt Service Coverage Ratios

The following table sets forth (i) the maximum annual debt service ("MADS") and the historic coverage of MADS for the Obligated Group for the fiscal years ended December 31, 2013 and 2014 and (ii) the pro forma MADS and pro forma coverage of pro forma MADS for the fiscal year ended December 31, 2014, as adjusted to reflect the issuance of the Bonds in the aggregate principal amount of $250,000,000, as if the Bonds had been issued on January 1, 2014.

Debt Service Coverage Ratios ($ Thousands)	2014	2013
Excess of Revenues Over Expenses	$ 146,891	$ 326,457
Unrealized (Gain) Loss on Investments	(10,787)	13,444
Unrealized Loss (Gain) on Interest Swap Agreements	42,800	(25,634)
Financing Costs[1]	18,991	19,440
Depreciation and Amortization	147,844	138,145
Income Available to Pay Debt Service	$ 345,739	$ 471,852
Actual Long-term Debt Service	$ 52,204	$ 83,706
Historical Coverage Ratio	6.6x	5.6x
Maximum Annual Debt Service[2]	$ 50,341	$ 50,225
Coverage Ratio of Maximum Annual Debt Service[3]	6.9x	9.4x
Pro-forma Maximum Annual Debt Service after 2015 Bond Issuance	$ 62,354	
Pro-forma Coverage Ratio of Maximum Annual Debt Service	5.5x	

(1) Excludes financing costs related to bank charges of $5,401 in 2014 and $5,151 in 2013.

(2) Maximum annual principal and interest payments on long-term debt for any succeeding fiscal year assuming an interest rate of 3.50%, as appropriate, on all variable rate debt. This analysis also factors in the anticipated effect of fixed payer interest rate swaps with notional amounts of $164.5 million (2009B&C), $121.2 million (2007C), $14.6 million (1998A), and $50 million (2001). Other funded debt included in the pro-forma maximum annual debt service, but not secured by an Obligation, issued under the Master Trust Indenture has an outstanding balance of $4.2 million as of December 31, 2014.

(3) The maximum annual debt service for the Obligated Group under the Master Trust Indenture debt is $49.7 million for the period ended December 31, 2014. The coverage ratio on only the Master Trust Indenture Debt is 7.0x for the Obligated Group at December 31, 2014.

Capital Expenditures

Allina Health has a capital budget of approximately $300 million per year, focused on both strategic investments and infrastructure needs. The capital budget and actual capital expenditures may be modified by Allina Health in response to operational performance, market conditions, and other factors. It is anticipated that the proceeds of the Bonds will be used for capital expenditures. Allina Health anticipates that future capital expenditures will be financed with a combination of existing cash and investments, operational cash flow, and, if market and other conditions are favorable, additional long-term borrowings.

Management's Discussion and Analysis of Results of Operations

Overview

Overall, Allina Health has delivered strong operating performance the last three years due to steadily growing revenue, stable volume growth, and physician integration. For 2014 Allina Health's revenue includes 42% inpatient revenue, 34% ambulatory revenue and 24% clinic revenue with compounded adjusted growth rates of 2.2%, 6.3% and 4.8%, respectively from 2009-2014. Allina Health implemented cost reductions, to support operating results during this period, through focused performance enhancement initiatives.

Six Months Ended June 30, 2015 Compared to Six Months Ended June 30, 2014

Operating income for the six months ended June 30, 2015 was $90 million compared to $27.6 million for the six months ended June 30, 2014. Excess of revenues over expenses for the six months ended June 30, 2015 was $135.9 million compared to $60.4 million of the six months ended June 30, 2014. The six-month period ended June 30, 2015 includes $36.7 million of non-operating contributions received in acquisitions related to the acquisition of District One Hospital in January 2015.

For the six months ended June 30, 2015 the operating margin was 4.8% compared to 1.6% for the six months ended June 30, 2014.

Key trends driving financial results for the six months ending June 30, 2015 include increased volumes, the acquisition of District One Hospital, the Health Catalyst arrangement (described in "Recent Initiatives and Developments"), and expense management.

Operating revenue growth remained steady with an increase of 9.1% for the six months ended June 30, 2015 compared to the six months ended June 30, 2014. District One Hospital revenue and the Health Catalyst arrangement account for 2.5% of the revenue growth.

For the six months ended June 30, 2015, inpatient admissions increased 0.2% while observation days increased 17.2% and outpatient volumes increased 7.7% over the comparative period in 2014. The Centers for Medicare and Medicaid Service ("CMS") "Two-Midnight Rule" initiated in 2013 is resulting in a shift to observation days from inpatient admissions. Clinic work RVUs increased 7.3% for the six months ended June 30, 2015 compared to the six months ended June 30, 2014.

Allina Health experienced a continued decrease of $11.9 million in uninsured, charity care, and bad debt expense for the six months ended June 30, 2015 compared to the six months ended June 30, 2014. Uncompensated care was 2.0% of gross patient charges in the six months ended June 30, 2015 compared to 2.4% for the same period in 2014. Decreases in charity care and uninsured discounts are attributable to increases in Medicaid and Prepaid Medical Assistance Program ("PMAP") enrollment under MNsure, the State of Minnesota's solution under the federally mandated Accountable Care Act ("ACA").

Investment returns for the six months ended June 30, 2015 resulted in a return of $13.1 million compared to a $56.2 million return for the six months ended June 30, 2014. Interest rate swap agreements had unrealized losses of $2.8 million and $21.9 million for the six months ended June 30, 2015 and 2014, respectively. The long-term investment portfolio total return was approximately 0.9% for the six month ended June 30, 2015 which was consistent with market conditions.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Operating income was $145.9 million compared to $133.4 million for 2013. Excess of revenues over expenses for the year ended December 31, 2014 was $146.9 million compared to $326.5 million for 2013. 2013 included $76.6 million of non-operating contributions received in acquisitions related to the acquisitions of Regina Hospital in September 2013 and Courage Center in June 2013.

Key trends driving financial results throughout 2014 included increased outpatient and clinical volumes offset by decreased inpatient volumes. Expense growth is driven primarily by acquisitions and investments in strategies to position the organization for health care reform and to better serve our patients for the long term.

Operating revenue growth remained steady with year-over-year increase of 5.4%. Regina Hospital and Courage Center revenue accounted for 1.3% of the revenue growth.

For the year ended December 31, 2014, inpatient admissions decreased 3.5% while observation days increased 27.1% and outpatient volumes increased 5.9% over the comparative year in 2013. The CMS "Two-

Midnight Rule" initiated in 2013 is resulting in a shift to observation days from inpatient admissions. Clinic work RVUs increased 4.6% in 2014 compared to 2013.

Allina Health experienced an overall decrease of $34.4 million in uninsured, charity care, and bad debt expense in 2014 compared to 2013. Uncompensated care is 2.2% of gross patient charges in 2014 compared to 2.7% in 2013. Decreases in charity care and uninsured discounts are attributable to increases in Medicaid and PMAP enrollment under MNsure.

Investment returns for the year ended December 31, 2014 resulted in a return of $47.0 million compared to a $93.0 million return for 2013. Interest rate swap agreements had unrealized losses of $42.8 million in 2014 compared to unrealized gains of $25.6 million in 2013. The long-term investment portfolio total return was approximately 4.1% for the year ended December 31, 2014 which was consistent with market conditions.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Regina Hospital and Courage Center are included in the consolidated financial statements for the four months ended and seven months ended December 31, 2013 due to their acquisitions in September and June 2013, respectively. The acquisitions account for approximately 1.1% of the revenue growth for 2013.

Operating income was $133.4 million compared to $128.0 million for 2012. Excess of revenues over expenses for the year ended December 31, 2013 was $326.5 million compared to $200.5 million for 2012. 2013 included $76.6 million of non-operating contributions received in acquisitions related to the acquisitions of Regina Hospital in September 2013 and Courage Center in June 2013.

Key trends driving financial results throughout 2013 included increased outpatient and clinical volumes offset by decreased inpatient volumes. Expense growth is driven primarily by acquisitions and investments in strategies to position the organization for health care reform and to better serve our patients for the long term.

Operating revenue growth remained steady with year-over-year increase of 4.3%. There was incremental 2013 net patient revenue of $39.6 million related to acquisitions. Other revenue increased $38.1 million due to joint venture earnings and philanthropic activity.

For the year ended December 31, 2013, inpatient admissions decreased 1.1% and outpatient volumes increased 0.7% over the comparative year in 2012. Clinic work RVUs increased 3.9% in 2013 compared to 2012.

Allina Health experienced an overall increase of $15.3 million in uninsured, charity care, and bad debt expense in 2013 compared to 2012. Uncompensated care is 2.7% of gross patient charges in 2013 compared to 2.4% in 2012.

Investment returns for the year ended December 31, 2013 resulted in a return of $93.0 million compared to a return of $88.7 million for 2012. Interest rate swap agreements had unrealized gains of $25.6 million in 2013 compared to unrealized losses of $13.0 million in 2012. The long-term investment portfolio total return was approximately 9.6% for the year ended December 31, 2013 which was consistent with market conditions.

Allina Health consolidated financial statements of operations includes non-obligated group members. These non-obligated group members incurred operating losses approximating $20.8 million for the year ended December 31, 2013 compared to $18.3 million for the year ended December 31, 2012. Regina Medical Center, Aspen Medical Group, and Quello Clinic merged into Allina Health and the Obligated Group effective December 31, 2013.

SYSTEM GOVERNANCE

Allina Health is a Minnesota nonprofit corporation exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. It is also exempt from state income taxation.

Allina Health has several tax-exempt and taxable subsidiaries. Certain of Allina Health's real estate is exempt from taxation under Minnesota law.

Allina Health is governed by a single board of directors (the "Board") that meets on a quarterly basis over a two-day period, including committee meetings. The Board oversees the operations of the entire Allina Health system. Allina Health's regional hospitals have boards of trustees which function in an advisory capacity. Allina Health subsidiaries have separate boards which are subject to the reserved powers of the Allina Health Board.

In addition to the directors elected by the Board, the Chief Executive Officer of Allina Health serves ex officio, with the right to vote. The bylaws prescribe three-year terms for elected members and limit elected members to two successive terms. The immediate past Chairperson of the Allina Health Board may be elected by the Board to hold office as director emeritus for a term of one year, and may be reelected for one additional one year term.

Upon a recommendation by the Governance & Nominating Committee of the Board that an elected director (other than the emeritus director) has qualifications that enhance the Board's effectiveness, that director may be elected to serve for up to three additional, consecutive, one-year terms. A former member of the Allina Health Board of Directors who has served the maximum term may return to Board membership after a one year hiatus.

The Board retains approval authority over all significant strategic and policy decisions. Many decisions are approved by the Board through its approval of the consolidated annual strategic and financial plan. Capital expenditures over a certain level and any significant debt incurrence require separate action by the Board.

The Board has seven standing committees: Audit and Compliance; Compensation; Finance; Investment; Governance and Nominating, Physician Governance; and Quality and Population Health.

Board of Directors

The following are Allina Health Board members (as of June 30, 2015):

Name	Profession / Association	Director Since:
John Church (Chairperson)	SVP Supply Chain General Mills, Inc.	2013
John Allen, MD	Clinical Chief of Digestive Diseases Yale University	2012
William Beer	Retired President and CEO Wenger Corporation	2007
Nate Garvis	President Naked Civics, LLC	2009
Laura Gillund	VP Human Resources and Professional Development C.H. Robinson Worldwide, Inc.	2015
Joseph Goswitz, MD	Pathologist Hospital Pathology Associates	2010
Greg Heinemann	Marketer, Executive, Entrepreneur	2014

Name	Profession / Association	Director Since:
Mark Jordahl (Director emeritus)	President, Wealth Management Group US Bancorp	2006
David Kuplic	Executive Vice President Advantus Capital Management Senior VP & Chief Investment Officer Securian Financial Group	2015
Hugh Nierengarten, JD	Attorney (retired) Nierengarten & Hippert, Ltd. Attorneys at Law	2009
Gloria Perez	President and CEO Jeremiah Program	2008
Brian Rosenburg, PhD	President Macalester College	2013
Deb Schoneman	CFO Piper Jaffray Companies	2013
Thomas S. Schreier, Jr.	Vice Chairman Nuveen Investments	2014
Abir Sen	Co-founder and CEO Gravie	2014
Mark Sheffert	Chairman and CEO Manchester Companies, Inc.	2009
Sally Smith	President and CEO Buffalo Wild Wings, Inc.	2012
Michael Tattersfield	President and CEO Caribou Coffee Company, Inc.	2010
Darrell Tukua	Partner (retired) KPMG LLP	2014
Penny Wheeler, MD (Ex-Officio)	President and CEO Allina Health	2015
Barbara Butts Williams, PhD	Dean of Business Capella University School of Business and Technology	2015

Allina Health's bylaws refer to all hospitals and other health related businesses owned or controlled by Allina Health (whether established as separately incorporated wholly controlled subsidiaries or unincorporated operating divisions) as "operating units." Allina Health is the sole member of the Obligated Group.

Conflict of Interest

As required by Allina Health's bylaws, the Board has adopted a conflict of interest policy requiring Board members, officers and key employees to promptly and fully disclose all actual or apparent conflicts

of interest and annually complete a conflict of interest disclosure statement. The policy prohibits an affected Board member from being present for a discussion of and participating in a vote on, any matter in which a conflict of interest exists. It also requires that the Board approve explicitly any transaction that might give rise to a conflict of interest concern.

Allina Health transacts business with firms with which members of the Board are affiliated. Management is of the opinion that these relationships do not represent material conflicts of interest.

Mark Jordahl, Director Emeritus of Allina Health's Board of Directors is President, Wealth Management Group at U.S. Bank, National Association, an affiliate of one of the underwriters of the Bonds. Deb Schoneman, a member of Allina Health's Board of Directors, is the Chief Financial Officer of Piper Jaffray Companies, an affiliate of one of the underwriters of the Bonds.

Darrell Tukua, a member of Allina Health's Board of Directors, is a retired partner of KPMG LLP, the independent auditors retained by Allina Health to review its consolidated financial statements.

MANAGEMENT

Organizational Design

Allina Health strategy is system-based, with strategic and capital planning conducted at the system level. The operating units develop business plans consistent with the system strategic plan. Several departments within Allina Health are managed centrally to ensure access to capital, a common approach to liability and risk issues, and direction of capital to achieve suitable returns. Management teams are in place to oversee the strategic direction and daily operations of the organization.

The Executive Leadership Team makes system-level decisions. This team includes the President and Chief Executive Officer; Executive Vice President, Administration and Chief Financial Officer; Chief Human Resource Officer; Chief Information Officer; Chief Medical Officer; General Counsel; Executive Vice President, Hospital and Specialty Services; Executive Vice President, Network/Integration Division; Executive Vice President, Allina Health Group; and presidents of ANW, Mercy, and United. The Executive Leadership Team provides an appropriate blend of clinical, operations and staff function expertise to ensure its ability to set strategy and oversee the execution of the organization's strategic plan.

The Clinical Leadership Team (the "CLT"), is comprised of the Chief Medical Officer, who serves as its chair, along with the Chairs of the Executive Quality Committees for Hospitals, Allina Health Group, and Home Care; the Quality Control Chair; one Metropolitan Hospital Vice President of Medical Affairs representative of the Hospital Division Quality Committee; one Community Hospital Vice President of Medical Affairs representative; and the Chair of the Nurse Executive Council. The CLT provides system-level coordination and oversight of clinically-related issues across the continuum of care. It is accountable to the Allina Health Quality Council and serves as its Executive Committee.

Management Personnel

Following are the Executive Leadership Team members and their biographies (as of June 30, 2015):

Penny Wheeler, M.D. (57) – *President and Chief Executive Officer*. Dr. Wheeler is the President and Chief Executive Officer. Prior to appointment as CEO, she served as the Chief Clinical Officer, a position she held since March 2006. As a board-certified obstetrician/gynecologist, Dr. Wheeler has served patients at Women's Health Consultants in Minneapolis and taught as an associate professor of obstetrics and gynecology at the University of Minnesota. She has served as President of ANW's medical staff, as Chair and Vice-Chair of the hospital's obstetrics and gynecology department and on numerous committees. Dr. Wheeler served on the Allina Health Board from 2002 until 2006, where she was Chair of the Quality Committee. Her educational background includes an undergraduate degree with honors from the University of Minnesota, and Doctor of Medicine from the University of Minnesota Medical School.

Chris Bent (45) – *Executive Vice President*, *Allina Health Group*. Ms. Bent leads the Allina Health Group, responsible for integrating primary care, specialty care and clinical service line capabilities to better serve the patients of Allina Health. Earlier in her career, Ms. Bent was the chief operating officer of the Minneapolis Heart Institute® where, in conjunction with the physician president, she provided professional management to the 125-bed Heart Hospital within ANW and Minneapolis Heart Institute®'s extensive outreach program. Her background is in physician practice management in both independent practices and integrated health care delivery systems. Ms. Bent graduated from Carleton College in Northfield, Minnesota with a Bachelor's Degree in Psychology and obtained her Master of Health Services Administration from the University of Minnesota.

Duncan Gallagher (55) – *Executive Vice President*, *Chief Administrative Officer and Chief Financial Officer*. Mr. Gallagher was appointed Chief Financial Officer in August, 2009. Prior to joining Allina Health, Mr. Gallagher was the Executive Vice President and Chief Operating/Financial Officer of Iowa Health System based in Des Moines, Iowa. He was also a partner in the healthcare consulting practice of KPMG LLP in Dallas, Texas with twelve years of experience at KPMG. Mr. Gallagher previously held various finance positions with HealthEast Care System in St. Paul, Minnesota. Mr. Gallagher received his Bachelor's Degree in Accounting from the University of South Dakota, and a Master of Business Administration from the University of Minnesota. In addition to Finance, Mr. Gallagher also has operational responsibility for Information Systems, Payer Relations and Contracting, Lab, Supply Chain Management and Revenue Cycle Management.

Susan Heichert (56) – *Senior Vice President, Chief Information Officer*. Ms. Heichert returned to Allina Health as Chief Information Officer in August 2010, after a brief departure. Ms. Heichert was part of the team that implemented the Electronic Health record. She has been working in healthcare informatics for over 25 years in various capacities. Ms. Heichert holds a Bachelor Degree in Nursing from the University of Maryland and a Masters from the University of Minnesota.

Christine Moore (45) – *Senior Vice President, Chief Human Resource Officer*. Ms. Moore joined Allina Health as Senior Vice President, Chief Human Resource Officer in August 2015. Prior to joining Allina Health, Ms. Moore was Vice President of Talent and Organization Development of Ecolab. Ms. Moore holds a Bachelor Degree in Economics from Scripps College and a doctorate in organizational psychology from Claremont Graduate University.

Daniel McGinty (53) – *Executive Vice President, Hospital and Specialty Services*. Mr. McGinty joined Allina Health from Duluth-based Essentia Health in September 2013. He worked in various capacities at Essentia over the previous 11 years. Most recently, he served as the chief administrative officer of Essentia's east region, responsible for seven hospitals, 18 clinics and a 475-physician multi-specialty clinic. Prior to his time at Essentia, Mr. McGinty was the president and CEO of Holy Family Memorial Health Network in Manitowoc, Wisconsin. Mr. McGinty has a Degree in Economics from Gustavus Adolphus College and a Master of Health Services Administration from the University of Minnesota. Mr. McGinty has operational responsibility for all Hospitals and Specialty Services.

Timothy Sielaff (52) – *Chief Medical Officer and Senior Vice President, Specialty Care and Research.* Dr. Sielaff was appointed Chief Medical Officer and Senior Vice President, Specialty Care and Research in February 2015. Dr. Sielaff has been a hepatopancreatobiliary surgeon for 15 years. Dr. Sielaff's educational background includes a Bachelor of Science Degree from the University of Wisconsin-Madison, a Doctor of Medicine from the Medical College of Virginia, a Doctor of Philosophy from the University of Minnesota-Department of Surgery, and a Master of Health Care Administration from the University of St. Thomas.

Robert Wieland, M.D. (52) – *Executive Vice President, Network/Integration Division.* Dr. Wieland assumed the role of Executive Vice President, Network/Integration Division in November 2014. Dr. Wieland has been employed by Allina Health in various roles since 1994, and served as the Executive Vice President, Clinic and Community Division from November 2008 until November 2014, and prior to that he was Vice President of Medical Affairs at ANW. Earlier in his career he was District Medical Director within the Allina Medical Clinic and is co-founder of the Hospitalist Service at ANW. Dr. Wieland earned his Bachelor's Degree in Mechanical Engineering at the University of Minnesota, medical degree at the University of Minnesota Medical School and Internal Medicine training at Abbott Northwestern Hospital. Dr. Wieland has accountability for the

Allina Integrated Medical Network, Strategy and Business Development, Care Management, HOME, and Allina Home Care, Hospice and Palliative Care and Marketing and Communication.

Elizabeth Truesdell Smith (52) – *Senior Vice President and General Counsel*. Ms. Smith assumed the role of General Counsel in February 2009. She joined the Allina Health Legal and Risk Management department in 2000. In 2007, Ms. Smith began leading Allina Health's medical-legal team as its Vice President. Before coming to Allina Health, Ms. Smith practiced as a trial lawyer for eight years with a focus on hospital and health law, medical professional liability and medical products liability litigation. She has worked in biomedical laboratory research at Harvard Medical School and in biomedical ethics at Boston University and the University of Minnesota. Ms. Smith earned a Master's of Public Health with a health law and bioethics concentration from Boston University School of Public Health and a Juris Doctor from the University of Minnesota Law School. Ms. Smith also has operational responsibility for Risk Services.

Ben Bache-Wiig, M.D. (57) – *System Vice President and President, Abbott Northwest Hospital*. Dr. Bache-Wiig was appointed President of ANW in October 2011. He served as Vice President of Medical Affairs for ANW since 2009. Dr. Bache-Wiig was previously Medical Director and Physician President of the North Clinic for 20 years. Dr. Bache-Wiig completed his undergraduate studies at Michigan State University and Doctor of Medicine at the University of Wisconsin. He is board certified in internal medicine. Dr. Bache-Wiig also has operational responsibility for WestHealth Ambulatory Center.

Sara J. Criger (54) – *System Vice President and President, Mercy Hospital*. Ms. Criger was appointed President of Mercy Hospital in July 2012. Prior to joining Allina Health, Ms. Criger was Vice President, HealthEast Care System and Chief Executive Officer, St. Joseph's Hospital, both based in St. Paul, Minnesota, for five years. Ms. Criger has more than 28 years of experience in managing large hospitals and clinics. Ms. Criger holds a Bachelor's Degree in Business Administration from Western Connecticut State University and a Master of Health Services Administration from the University of St. Francis. Ms. Criger also has operational responsibility for Buffalo Hospital, Unity and AHP.

Tom O'Connor (49) – *System Vice President and President, United Hospital*. Mr. O'Connor was appointed President of United in January 2012. Previously, he served as President of Mercy Hospital for five years and President of St. Francis for five years. Before St. Francis, he served for a year as the Divisional Vice President of Operations of Allina Healthcare Improvement Resources and for four years as the Vice President of Operations of Allina Regional Health Services. He also spent three years as Chief Operating Officer of HCA Capital Medical Center in Tallahassee, Florida and two years as an Assistant Administrator and Quality Coach at the HCA Gulf Coast Hospital in Panama City, Florida. Mr. O'Connor holds a Bachelor of Arts Degree from St. Olaf College, a Master of Health Services Administration and a Master of Business Administration from the University of Minnesota. Mr. O'Connor also has operational responsibility for River Falls Hospital, and AHEMS.

Centralized Functions

Allina Health provides certain management functions to its hospitals, divisions and subsidiaries through a corporate shared-service structure, which is generally focused on risk management and strategic direction of the organization as well as on providing financial economies of scale. These functions include strategy and business development, marketing and communications, legal, risk management, insurance, information systems, community benefits and engagement, philanthropy, compliance, treasury, public policy and government relations, and certain components of finance, public relations, human resources, purchasing, real estate, clinical knowledge management, clinical integration, clinical service lines and quality resources, and care management.

Allina Health negotiates third-party payer contracts through a central payer relations and contracting department. This approach permits Allina Health to concentrate its expertise in market conditions and payer methodology in a single group and to maintain a unified, coherent approach to dealing with third party payers.

Allina Health has a centralized revenue management function to manage the complex process of registering patients, billing for services performed, and collecting payment for services.

Compliance and Regulatory Matters

Allina Health operates a Medicare and Medicaid billing compliance program designed to foster a culture that promotes prevention, detection and resolution of billing errors. It is a comprehensive program of policies, documentation, education, monitoring, reporting and enforcement designed to ensure to the maximum extent possible that claims submitted on behalf of the organization are accurate and supported by reliable documentation. The goal of Allina Health's compliance programs is to minimize the level of error and facilitate correction of errors as soon as they are detected. Detection of such errors may result in disclosures to various regulatory agencies from time to time, the outcomes of which cannot be predicted with certainty. It is possible that such disclosures could result in allegations of noncompliance with certain health care laws, which could ultimately involve material payments, fines, and penalties. Nonetheless, management believes that these programs are functioning well and that they continuously improve Allina Health's compliance with billing requirements.

Excellian (Automated Medical Record / Revenue Cycle System Technology)

Allina Health implemented a fully integrated clinical information system into its hospitals and clinics, known as Excellian, using Epic Systems Corporation technology, in 2009. Benefits of the system include: ease in registration, ability to access medical records on-line, decreased wait time in the emergency room, evidenced based clinical tools to guide the most effective treatment, safety alerts to prevent medical error and a unified patient record.

Medicare and Medicaid Electronic Health Records Incentive Programs (Meaningful Use)

The American Recovery and Reinvestment Act of 2009 established the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act authorized the CMS to establish the Meaningful Use Program to achieve national healthcare goals through the use of electronic health records. Through the Meaningful Use Program, organizations and eligible providers will receive incentives for meeting steadily more challenging electronic health record use criteria from 2011 through 2015.

The hospitals of Allina Health attested to the federal government that they met 19 objective measures and 15 quality measures in Stage Two, Year One of Meaningful Use. The physicians of Allina Health also continue to meet Stage One measures along with the new Stage Two requirements of the Meaningful Use physician attestation process. As a result, Allina Health recorded grant revenue of $14.8 million, $23.5 million and $20.4 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Philanthropy

Allina Health has six foundations (collectively, the "Foundations") supporting health-related services: Abbott Northwestern Hospital Foundation; Allina Associated Foundation; Courage Kenny Foundation; Mercy & Unity Hospitals Foundation; Phillips Eye Institute Foundation; and United Hospital Foundation. Each foundation is a separate tax-exempt, Minnesota non-profit corporation and wholly owned affiliate of Allina Health. The foundations raise funds through gifts, contributions and grants and are operated exclusively to support the functions of and to assist in carrying out the charitable purposes of Allina Health. Donations to the Foundations for the years ending December 31, 2014, 2013, and 2012 totaled $36.7 million, $26.5 million, and $27.5 million, respectively. As of December 31, 2014, the Foundations had total net assets of $213.9 million

Recent Initiatives and Developments

District One Hospital

Allina Health and Rice County District One Hospital entered into an Affiliation Agreement that included the transfer of substantially all assets and liabilities of Rice County District One Hospital to Allina Health on January 1, 2015. Legislative approval for the transaction was obtained from the Minnesota State Legislature on April 30, 2014. The transfer resulted in Allina Health recognizing an unrestricted nonoperating contribution received

in acquisition of $36.7 million. The District One Hospital is a 49 bed community health care facility located in Faribault, Minnesota, with annual operating revenues of $46 million.

Health Catalyst

Allina Health and Health Catalyst entered into a partnership effective January 1, 2015 to create a national model for data-driven health delivery. The transaction includes a service agreement and Health Catalyst equity in exchange for the breakthroughs in analytics and outcomes improvement that Allina Health has developed since mid-2010 – a deep set of capabilities in areas such as predictive modeling, clinical care improvement and readmissions reduction. Health Catalyst provides data warehouse platform and analytics applications to more than 1,900 client hospitals and clinics.

THE HEALTH CARE ENVIRONMENT

Minneapolis-St. Paul Environment

Allina defines its primary market as the 11-county metropolitan Minneapolis-St. Paul area. Population growth has averaged 5% over the last 5 years. According to U.S. Census 2013 estimates, the Minneapolis St. Paul area had a population of approximately 3.8 million. Within this population, the 55-64 and the 65 and older age groups are increasing as a percentage of the total population. The 65 and older age group is projected to make up 14.7% of the population by 2020. In general, the population is well-educated and enjoys relatively high per capita income with widespread home ownership. It also enjoys low unemployment (3.79% as of March 2015 per the Bureau of Labor Statistics) and a low level of uninsured compared to other areas across the country.

The metropolitan Minneapolis-St. Paul area is a mature managed care market. A significant portion of health care in the market is delivered through health maintenance organizations and preferred provider organizations. Over half of employers self-insure for employee health coverage. As healthcare costs continue to increase at rates above general inflation, employers are offering more plan designs that encourage employees to help manage costs through reduced utilization. Such plans include high deductibles and increasing levels of co-insurance. Health plans are offering more cost sensitive plans to enrollees, including tiered networks, price catalogs and other transparency tools to segment providers and continue pressure on prices. Payers and providers, separately and together, are exploring options to connect portions of reimbursement to clinical outcomes improvement. Capitation is not a significant mechanism for payment for healthcare services in this market.

As state and federal programs experiment with value-based purchasing models to improve quality, reduce costs and extend solvency, providers will be required to incur additional costs for care management, training, coding, abstracting, reporting and billing. There is movement from traditional Medicare and Medical Assistance programs to Managed Medicare, PMAP and MNCare.

Over time, the long-term trend of downward pressure on health care costs in the metropolitan area has resulted in consolidation and vertical integration between payers and providers, and between hospitals and clinics. A small number of large health care systems have emerged from this consolidation activity. In addition to Allina Health, these include: (1) Fairview Health Services ("Fairview"), which operates Fairview Southdale Hospital, Fairview Ridges Hospital, University of Minnesota Medical Center – Fairview, Fairview Northland Medical Center, Fairview Lakes Medical Center and a medical practice group, Fairview Physician Associates; (2) HealthEast, which operates St. Joseph's Hospital, St. John's Northeast Community Hospital and Woodwinds Health Campus on the east side of the metropolitan area, as well as several clinics; (3) Children's Hospitals and Clinics, which operates pediatric hospitals in Minneapolis and St. Paul, as well as pediatric units at other adult acute-care hospitals; (4) HealthPartners provider operations owns and operates Regions Hospital in St. Paul, Methodist Hospital in St. Louis Park, Minnesota, and Lakeview Hospital in Stillwater, Minnesota, as well as clinics throughout the Twin Cities area, and several health plans. HealthPartners is also a co-owner of St. Francis with Allina. Fairview and North Memorial Medical Center are also co-owners of Maple Grove Hospital. Only two hospitals, North Memorial Medical Center and Hennepin County Medical Center, remain as independent hospitals. Both of these hospitals have physician group components.

The provider market is also primarily concentrated around four large health systems: Allina Health, Fairview, HealthEast, and HealthPartners. Because the payer organizations primarily market on open access networks and products, generally all providers are in network with all of the payers. With patients bearing much more of the expense of health care, providers are finding themselves competing on price and quality.

There are three principal payer organizations in the metropolitan area; Blue Cross/Blue Shield of Minnesota, Medica and HealthPartners. Each now also has a national PPO partner (BCBS Association, United HealthCare with Medica and Cigna with HealthPartners) which has led to a conversion of most national PPO membership to one of these local-national partnerships. PreferredOne is much smaller but continues to compete in the PPO and TPA areas. Together these payers compete vigorously for the provision of health coverage to employers and to individuals. Blue Cross continues to report the highest membership, followed by Medica and HealthPartners, respectively. UCARE operates in the government managed care area with the largest PMAP and Medicare Advantage population.

METROPOLITAN MARKET SHARE ANALYSIS

Market Share

Allina Health metropolitan hospitals have maintained the leading market position for acute care services in the Minneapolis-St. Paul area. Over the three-year period from 2012 through 2014, as exhibited in the following table, Allina Health market share decreased slightly by 0.7% to 31.6%, but remains well above the second highest competitor.

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Discharges by Metropolitan Hospitals
(Excluding Newborns/Neonatal)

Hospital Name	Discharges 2014	Discharges 2013	Discharges 2012	Market Share Percentage 2014	Market Share Percentage 2012	Change
Allina Health						
Abbott Northwestern	36,498	37,817	37,012	12.1%	11.9%	0.2%
United Hospital	21,724	22,475	23,685	7.3	7.6	-0.3
Mercy Hospital	18,567	19,631	20,160	6.2	6.4	-0.2
Unity Hospital	11,196	12,117	12,180	3.7	3.9	-0.2
PEI*	6	124	135	0.0	0.0	0.0
St. Francis Regional	5,162	5,266	5,501	1.7	1.8	-0.1
Regina – Hastings**	1,761	1,934	2,075	0.6	0.7	-0.1
	94,914	99,364	100,748	31.6%	32.3%	-0.7%
Fairview						
Fairview Ridges	10,539	10,337	10,831	3.5	3.5	0.0
Fairview Univ Med Ctr	33,051	32,751	32,649	11.0	10.4	0.6
Fairview Southdale	17,432	17,054	17,983	5.8	5.8	0.0
	61,022	60,142	61,463	20.3	19.7	0.6
HealthEast						
St. Johns	11,849	12,696	13,950	3.9	4.5	-0.6
St. Josephs	10,788	11,419	12,217	3.6	3.9	-0.3
Woodwinds	7,181	7,370	7,514	2.4	2.4	0.0
	29,818	31,485	33,681	9.9	10.8	-0.9
North Memorial	16,900	18,726	21,407	5.6	6.8	-1.2
Maple Grove Hospital* **	8,313	7,652	7,061	2.8	2.3	0.5
Methodist Hospital	20,279	20,067	21,141	6.7	6.8	-0.1
Regions (St. Paul Ramsey)	24,827	23,448	23,987	8.3	7.7	0.6
Hennepin County Med Ctr	20,541	20,776	20,388	6.8	6.5	0.3
Ridgeview – Waconia	6,124	5,875	5,945	2.0	1.9	0.1
Children's						
Children's Mpls	6,864	6,282	6,492	2.3	2.1	0.2
Children's – St. Paul	4,963	4,296	4,042	1.7	1.3	0.4
	11,827	10,578	10,534	4.0	3.4	0.6
Lakeview – Stillwater	3,683	3,546	3,540	1.2	1.1	0.1
Gillette Children's	2,446	2,322	2,329	0.8	0.7	0.1
Totals	**300,694**	**303,981**	**312,224**	**100.0%**	**100.0%**	**0.0%**

* PEI experienced a significant shift from inpatient to observation under the Centers for Medicare and Medicaid Service (CMS) "Two Midnight Rule."

** As of September 1, 2013, Regina is wholly owned by Allina Health.

*** Maple Gove Hospital is 75% owned by North Memorial and 25% owned by Fairview.

Source: Minnesota Hospital Association.

INVESTMENT MANAGEMENT

The Investment Committee, a committee of Allina Health's Board, is responsible for overseeing asset allocation studies, evaluating and selecting an independent investment consultant, developing investment objectives, guidelines, and performance measurement standards, evaluating and selecting investment managers and reviewing and evaluating the results of each investment component and the overall performance of all invested funds.

Investment Pools

Allina Health maintains its unrestricted investments in cash, money market funds and short term fixed income (liquidity assets), which are utilized for liquidity and preservation of capital, and diversified long term investments (long-term assets), which are utilized for capital growth. The allocation between liquidity and long-term assets depends on the liquidity and strategic needs of the organization. The following table allocates assets based on investment strategy, and will vary from the audited fair value footnote, which looks through the investment strategies to the underlying holdings.

Allina Health periodically reviews asset allocation to ensure that the organization is maintaining the appropriate portfolio allocation, consider other asset classes and to address shifts in market expectations. The Investment Committee approved a new asset allocation target in the first quarter of 2013, which is reflected in the following table. The move toward the new asset allocation targets was completed in the first quarter 2014.

Unrestricted Cash and Investments – Asset Allocation ($ thousands)

Unrestricted Balances	**Target**	**June 30, 2015**		**December 31, 2014**		**December 31, 2013**	
Cash and Money Market		9.8%	167,100	10.5%	180,985	8.4%	132,704
Short-Term Fixed Income		20.3	346,434	20.8	357,511	20.1	315,058
Total Liquidity Assets	**25.0%**	**30.1%**	513,534	**31.3%**	538,496	**28.5%**	447,762
Long-Term Assets	**75.0%**	**69.9%**	1,194,362	**68.7%**	1,180,534	**71.5%**	1,123,312
Total Unrestricted Assets		**100.0%**	1,707,896	**100.0%**	1,719,030	**100.0%**	1,571,074

Asset Allocation – Asset Class							
Investment	Current Target Allocation	6/30/2015 % of Long-Term Assets	6/30/2015 % Total Unrestricted Investments	12/31/2014 % of Long-Term Assets	12/31/2014 % of Total Unrestricted Investments	12/31/2013 % of Long-Term Assets	12/31/2013 % Total Unrestricted Investments
Global Equity	32.0%	32.0%	22.4%	31.7%	21.8%	33.1%	23.6%
Long/Short Equity Hedge Funds	5.0	5.7	4.0	5.4	3.7	4.4	3.1
Global Fixed Income	35.0	34.9	24.4	35.5	24.4	34.5	24.7
Fund of Hedge Funds	0.0	0.1	0.1	0.1	0.1	7.3	5.2
Opportunities and Other	20.0	19.2	13.4	19.2	13.2	12.6	9.0
Real Assets	8.0	8.1	5.6	8.1	5.5	8.1	5.9
Total Long-Term	100.0%	100.0%	69.9%	100.0%	68.7%	100.0%	71.5%
Cash and Money Market			9.8%		10.5%		8.4%
Short-Term Fixed Income			20.3		20.8		20.1
Total Liquidity			**30.1%**		**31.3%**		**28.5%**

In 2013 Allina Health liquidated its fund of hedge funds managers, reduced overall hedge fund exposure and invested in eight direct hedge funds. Three of these direct hedge funds are invested in distressed debt and strategic fixed income and are included in the opportunistic and other allocation. Five additional long/short equity direct hedge funds are considered a part of the overall global equity component. There is one remaining fund of hedge funds manager that is in liquidation. Allina Health also added three direct investments in private capital with funding commitments that will be drawn down over the next several years. As of December 31, 2014 these holdings represented approximately 1.5% of unrestricted assets.

Liquidity

Days Cash on Hand is calculated for any period tested, as the aggregate amount of unrestricted and unencumbered cash, cash equivalents and investments divided by the quotient of operating expenses less depreciation for the rolling twelve months ended for the period tested divided by 365.

Days Cash on Hand
($ thousands)

	For the Period July 1, 2014 – June 30, 2015	For the Years Ended December 31,		
		2014	2013	2012
Operating Expenses	$3,552,270	$3,457,737	$3,287,126	$3,150,339
Depreciation	(149,673)	(147,844)	(138,145)	(132,564)
Cash Flow Expenses	3,402,597	3,309,893	3,148,981	3,017,775
Daily Average Expenses	9,322	9,068	8,627	8,268
	June 30, 2015	**December 31, 2014**	**December 31, 2013**	**December 31, 2012**
Total Cash and Investments	$1,707,896	$1,719,030	$1,571,074	$1,444,359
Days Cash on Hand	**183.2**	**189.6**	**182.1**	**174.7**

Debt and Swap Structure

Allina Health holds a mix of both fixed and variable rate long-term debt. The chart below displays the structure, and provides detail regarding credit enhancement and expiration of the credit agreement, if applicable. Allina Health also hedges a portion of its variable rate interest risk through interest rate swaps. The June 30, 2015 valuations are given below, along with the swap rates and counterparties.

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Allina Health's Current Debt Structure as of June 30, 2015

Series	$ Outstanding (thousands)	Structure	Final Maturity	Credit Enhancement / Purchaser	LOC Expiration
2014	$ 20,165	Fixed Rate – Private Placement	2028	Union Bank	
2009A	175,275	Fixed Rate	2029	None	
2009B	114,525	Daily VRDB	2035	JP Morgan LOC	January 2017
2009C	50,000	Weekly VRDB	2035	Wells Fargo LOC	January 2017
2007A	105,415	Fixed Rate	2022	MBIA Insured	
2007C	121,250	Weekly VRDB	2034	Wells Fargo LOC	January 2017
1998A	14,575	Auction Rate	2022	MBIA Insured	
1993B	24,900	Auction Rate	2017	Ambac Insured	
	626,105	Total Bonds			
Other***	8,280				
	$634,385	**Total Debt**			

Fixed Rate	$ 300,855	47.4%	
Hedged Variable Rate**	300,350	47.3	(2009B, 2009C, 2007C & 1998A)
Unhedged Variable Rate	24,900	3.9	
Other	8,280	1.3	
Total	**$634,385**		

* Interest rates are interest cost only, and do not include administrative, credit facility, broker or other costs related to the issuance of the bonds.

** There is a $50 million swap that does not have any underlying associated debt and the 1998A swap has $500 thousand in additional notional value relative to the outstanding debt. If the $50 million swap and the additional $500 thousand 1998A notional were applied to current unhedged variable rate bonds, all bonds would be fixed or hedged, with hedged variable rate debt making up 51.3% of total debt, totaling $325 million.

*** Other debt includes any premiums or discounts associated with fixed rate debt, capital leases, and other small notes and loans that are included in debt on the balance sheet.

Fixed Payer Interest Rate Swaps as of June 30, 2015
($ thousands)

Swap	Balance Sheet Location	Fair Value Liability	Notional Outstanding	Rate Paid	Rate Received	Counterparty	Collateral Threshold
2009B & C	Other Liabilities	$31,751	$123,394	3.73%	% of Libor	JP Morgan	30,000
2009B & C	Other Liabilities	10,612	41,131	3.74%	% of Libor	Wells Fargo	20,000
2007C	Other Liabilities	24,968	121,250	3.58%	% of Libor	US Bank	40,000
2001	Other Liabilities	17,150	50,000	5.17%	SIFMA	Goldman Sachs	--
1998A	Other Liabilities	2,471	15,075	4.44%	SIFMA	Goldman Sachs	--
Total		**$86,952**	**$350,850**				

As of June 30, 2015, Allina Health had $2.5 million of collateral posted related to the swaps. Allina Health posts collateral related on its swaps when mark to market valuations breach the contractually established threshold. Collateral is posted in the form of cash and is adjusted on a daily basis.

Fair value swap valuations require non-performance risk (i.e. credit risk) to be included in the valuation. Non-performance risk is defined as the risk that the obligation will not be fulfilled and affects the value at which the liability is transferred. This non-performance risk is determined by adjusting the discounting rate by a credit spread as of the reporting date. The addition of the credit spread to the discounting rate reduces the reported liability. The fair value reported liability of the swaps is approximately $3.3 million less than the mark-to-market valuations.

EMPLOYEES

As of December 31, 2014 Allina Health employed approximately 24,600 full-time and part-time personnel, or approximately 20,400 full-time equivalents. Compensation and benefits include medical and disability, retirement, life and paid time off plans. Approximately 41% of Allina Health's employees are unionized. This level of unionization is typical in the market served by Allina Health. The largest union is the Minnesota Nursing Association ("MNA"), at 52% of Allina Health's unionized employees.

Labor agreements are generally negotiated with two or three year terms. Allina Health will begin negotiations to renew the MNA contracts for metropolitan facilities ANW, Mercy, PEI, United and Unity which expire May 31, 2016. Allina Health renewed contracts with certain groups of Service Employees International Union ("SEIU") employees in April 2015. In July 2015, SEIU began representing approximately 350 services employees at Unity Hospital.

EMPLOYEE RETIREMENT PLANS

Allina Health employees are eligible to participate in employee benefits programs, including a defined contribution 401(k) plan. The 401(k) plan includes an annual non-elective employer contribution for eligible employees, based on years of vesting service, and a defined-contribution match, in which 50% of the employees' initial 4% of salary contributions is matched.

Allina Health employees participated in a defined-benefit cash-balance pension plan. This plan was frozen on December 31, 2008 and fully terminated effective December 31, 2012. The plan assets were distributed to participants in November 2013 and there is no further liability associated with this plan.

Certain union (contract) employees are eligible to participate in multi-employer pension plans. Contributions to the multi-employer pension plans are made in accordance with the collective bargaining agreements. Allina Health contributes more than 5% of the total contributions to all of the plans in which it participates. Allina Health is required to make minimum contributions each year and will make contributions of $34.9 million in 2015. Allina Health's portion of the withdrawal liability from the multi-employer plans is $71.9 million.

INSURANCE PROGRAM

Allina Health manages professional and general liability exposure through a layered program including a significant self-insured retention and $85 million of transferred risk limits on a claims made basis (above that retention.) The self-insured layer covers individual claims up to $8 million, with $30 million of annual aggregate exposure. Allina Health maintains a strong, internal claims and litigation management function to manage claims. For the most part, Allina Health records professional and general liability as a general liability of the system. If claims-made policies presently in force are not renewed or replaced with equivalent insurance or an extended reporting endorsement not purchased, claims asserted after the end of the policy term will be uninsured.

Allina Health manages exposure for the following through commercial plans, subject to certain deductibles and self-insured retention: (a) property insurance including: buildings, building contents, business interruption, accounts receivable, electronic data processing, and valuable papers; (b) directors' and officers' liability insurance, including employment practices liability; (c) crime; (d) fiduciary; (e) helipad; and (f) non-owned air craft. Allina Health self-insures for workers' compensation and employer's liability insurance within Minnesota's statutory retention with excess coverage funded through the state reinsurance company. Allina Health also self-insures its auto liability up to $2 million; losses exceeding $2 million are included in the excess insurance program. Allina Health maintains a separate policy for Wisconsin workers' compensation, auto liability and a separate professional liability policy that meets the Wisconsin State patient compensation fund for coverage.

CONTINGENCIES

Allina Health has provided guarantees for the debt of related parties and certain other commitments through 2016. The guarantees totaled $0.5 million at June 30, 2015. No liability has been recorded, and no payments have been required under the guarantees.

LITIGATION

Allina Health is, from time to time, a defendant in various lawsuits arising in the ordinary course of business. Although the outcome of these lawsuits cannot be predicted with certainty, Allina Health believes the ultimate disposition of such lawsuits will not have a material adverse effect on Allina Health's financial condition.

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APPENDIX B

CONSOLIDATED FINANCIAL STATEMENTS FOR ALLINA HEALTH SYSTEM FOR THE FISCAL YEARS ENDED DECEMBER 31, 2014, 2013, AND 2012

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ALLINA HEALTH SYSTEM

Consolidated Financial Statements

December 31, 2014, 2013, and 2012

(With Independent Auditors' Report Thereon)

ALLINA HEALTH SYSTEM

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KPMG LLP
4200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402

Independent Auditors' Report

The Board of Directors
Allina Health System:

We have audited the accompanying consolidated financial statements of Allina Health System (the System), which comprise the consolidated balance sheets as of December 31, 2014, 2013, and 2012, and the related consolidated statements of operations and changes in net assets, and cash flows for each of the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Allina Health System as of December 31, 2014, 2013, and 2012, and the results of their operations and their cash flows for each of the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Minneapolis, Minnesota
March 10, 2015

ALLINA HEALTH SYSTEM

Consolidated Balance Sheets

December 31, 2014, 2013, and 2012

(Dollars in thousands)

Assets		2014	2013	2012
Current assets:				
Cash and cash equivalents	$	180,985	132,704	147,405
Short-term investments		357,511	315,058	341,033
Patient accounts receivable, less allowances for uncollectible accounts of $70,285 in 2014, $84,088 in 2013, and $59,398 in 2012		419,522	405,095	385,761
Inventories		55,311	53,146	53,088
Other current assets		109,389	75,126	60,469
		1,122,718	981,129	987,756
Investments		1,180,534	1,123,312	955,921
Investments with limited uses		150,162	152,555	131,539
Land, buildings, and equipment, net		1,041,950	1,050,770	956,776
Other assets		246,553	225,597	176,732
Total assets	$	3,741,917	3,533,363	3,208,724
Liabilities and Net Assets				
Current liabilities:				
Accounts payable and accrued expenses	$	428,185	420,116	391,905
Other current liabilities		101,760	117,138	118,766
		529,945	537,254	510,671
Long-term debt		613,294	614,806	634,722
Other liabilities		420,545	369,909	426,093
Total liabilities		1,563,784	1,521,969	1,571,486
Net assets:				
Unrestricted		2,008,030	1,857,436	1,501,921
Temporarily restricted		115,155	98,925	89,536
Permanently restricted		54,948	55,033	45,781
Total net assets		2,178,133	2,011,394	1,637,238
Total liabilities and net assets	$	3,741,917	3,533,363	3,208,724

See accompanying notes to consolidated financial statements.

ALLINA HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2014, 2013, and 2012

(Dollars in thousands)

	2014	2013	2012
Revenues:			
Patient service revenue net of contractual adjustments	$ 3,465,733	3,291,537	3,173,116
Provision for bad debts	(93,547)	(90,581)	(76,201)
Net patient service revenue	3,372,186	3,200,956	3,096,915
Other operating revenue	231,495	219,609	181,458
Total revenues	3,603,681	3,420,565	3,278,373
Expenses:			
Salaries and benefits	2,240,474	2,096,786	2,038,575
Supplies and services	787,580	758,210	721,793
Depreciation and amortization	147,844	138,145	132,564
Financing costs	24,392	24,591	25,989
State assessments and taxes	79,481	75,787	70,852
Utilities and maintenance	74,317	71,179	63,323
Other operating expenses	103,649	122,428	97,243
Total expenses	3,457,737	3,287,126	3,150,339
Operating income	145,944	133,439	128,034
Nonoperating gains (losses):			
Investment return	46,990	92,983	88,713
Gains (losses) on interest rate swap agreements	(42,800)	25,634	(13,029)
Contributions received in acquisitions	—	76,611	—
Other	(3,243)	(2,210)	(3,237)
Excess of revenues over expenses	146,891	326,457	200,481

ALLINA HEALTH SYSTEM

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2014, 2013, and 2012

(Dollars in thousands)

	2014	2013	2012
Unrestricted net assets:			
Excess of revenues over expenses	$ 146,891	326,457	200,481
Net assets released from restrictions for capital purposes	7,080	18,469	7,260
Amortization of unrealized loss on interest rate swap agreement	874	874	874
Other	(4,251)	9,715	565
Increase in unrestricted net assets	150,594	355,515	209,180
Temporarily restricted net assets:			
Contributions	31,884	18,982	27,312
Contributions received in acquisitions	—	12,188	—
Investment return	4,360	9,280	7,621
Net assets released from restrictions	(21,151)	(30,255)	(15,856)
Other	1,137	(806)	95
Increase in temporarily restricted net assets	16,230	9,389	19,172
Permanently restricted net assets:			
Contributions for endowment funds	396	209	760
Contributions for endowment funds received in acquisitions	—	9,537	—
Investment return	34	106	80
Other	(515)	(600)	(1,215)
Increase (decrease) in permanently restricted net assets	(85)	9,252	(375)
Increase in net assets	166,739	374,156	227,977
Net assets at beginning of year	2,011,394	1,637,238	1,409,261
Net assets at end of year	$ 2,178,133	2,011,394	1,637,238

See accompanying notes to consolidated financial statements.

ALLINA HEALTH SYSTEM

Consolidated Statements of Cash Flows

Years ended December 31, 2014, 2013, and 2012

(Dollars in thousands)

	2014	2013	2012
Operating activities:			
Increase in net assets	$ 166,739	374,156	227,977
Adjustments to reconcile increase in net assets to net cash and cash equivalents provided by operating activities:			
Depreciation and amortization	147,844	138,145	132,564
Provision for bad debts	93,547	90,581	76,201
Goodwill impairment	1,454	1,341	1,848
Loss (gain) on sales of land, buildings, and equipment	(2,236)	778	(595)
Unrealized loss (gain) on interest rate swaps	29,273	(39,260)	(738)
Realized and unrealized gains on investments, net	(27,775)	(83,668)	(79,070)
Restricted contributions	(32,280)	(19,191)	(28,072)
Contributions of cash for long-lived assets	(3,288)	(1,393)	(2,327)
Contributions received in acquisitions	—	(98,336)	—
Earnings on joint ventures	(12,988)	(15,342)	(11,840)
Pension plan expenses	8,666	10,819	69,294
Pension plan contributions	(1,347)	(52,916)	(46,000)
Changes in assets and liabilities net of acquisition:			
Change in accounts receivable and other current assets	(142,734)	(111,684)	(87,853)
Change in accounts payable and other current liabilities	8,103	8,378	(9,066)
Change in other assets and liabilities	(6,281)	(37,816)	(9,425)
Net cash and cash equivalents provided by operating activities	226,697	164,592	232,898
Investing activities:			
Proceeds from sales of land, buildings, and equipment	39,458	57,839	2,122
Purchases of land, buildings, and equipment	(169,747)	(213,603)	(210,312)
Contributions of cash for long-lived assets	3,288	1,393	2,327
Cash received in acquisitions	—	2,399	—
(Purchases) sales of investments classified as trading	(64,910)	(13,239)	(43,425)
Sales (purchases) of investments with limited uses	(4,597)	16,629	9,497
Draws on construction funds	—	—	3,917
Distributions received from joint ventures	11,767	11,776	12,820
Contributions to joint ventures	(1,187)	(4,160)	(4,935)
Net cash and cash equivalents used in investing activities	(185,928)	(140,966)	(227,989)
Financing activities:			
Restricted contributions, net	32,280	19,191	28,072
Change in pledges receivable	(8,373)	1,128	(22)
Change in outstanding checks payable	3,609	(8,065)	18,785
Draw on line of credit	—	19,965	—
Principal payment on line of credit	(19,965)	—	—
Proceeds from issuance of note payable	20,165	—	—
Principal payments of long-term debt	(20,204)	(70,546)	(28,587)
Net cash and cash equivalents provided by (used in) financing activities	7,512	(38,327)	18,248
Increase (decrease) in cash and cash equivalents	48,281	(14,701)	23,157
Cash and cash equivalents at beginning of year	132,704	147,405	124,248
Cash and cash equivalents at end of year	$ 180,985	132,704	147,405
Schedule of noncash financing activity:			
Capitalized lease	$ —	—	336

See accompanying notes to consolidated financial statements.

(1) Organization and Basis of Presentation

Allina Health System (the System) is a not-for-profit corporation whose consolidated financial statements include the accounts of its owned subsidiaries and controlled affiliates.

The System consists of five hospitals located in the Minneapolis and Saint Paul metropolitan area, six hospitals located outside the metropolitan area, physician clinics employing approximately 1,310 providers, various other health care-related entities, and seven foundations supporting health-related services.

In June 2013, the System acquired Courage Center, and became the sole owner (note 19).

In September 2013, the System acquired the remaining 75% interest of its joint venture in Regina Medical Center, and became the sole owner (note 19).

All significant intercompany accounts and transactions have been eliminated in the consolidated financial statements.

(2) Summary of Significant Accounting Policies

(a) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in these consolidated financial statements and accompanying notes. Although estimates are considered to be fairly stated at the time the estimates are made, actual results could differ from those estimates.

(b) Cash and Cash Equivalents

Cash and cash equivalents include bank deposits and short-term investments with an original maturity of three months or less from the date of purchase that have not otherwise been classified as long-term assets due to a designation for long-term purposes.

(c) Pledges Receivable

Pledges are recorded in the period that the pledges are made and represent unconditional promises to give. Pledges that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. A discount on each pledge is computed using the risk-free interest rate available at the time the pledge was made for the duration of the pledge. An allowance for uncollectible pledges receivable is determined based on a review of estimated collectibility and historical experience.

(d) Derivative Financial Instruments

The System uses interest rate swaps as part of its risk-management strategy to manage exposure to fluctuations in interest rates and to manage the overall cost of its debt. Interest rate swaps are used to hedge identified and approved exposures. Interest rate swaps are recognized as either assets or

(Continued)

liabilities in accordance with the netting provisions in the counterparty agreement and are measured at fair value.

The System accounts for its interest rate swaps in accordance with Accounting Standards Codification (ASC) Topic 815, *Derivatives and Hedging*, which requires entities to recognize all derivative instruments as either assets or liabilities in the consolidated balance sheets at their respective fair values.

For interest rate swaps that are not designated as cash flow hedges, gains or losses resulting from changes in the fair values of the interest rate swaps are reported as nonoperating gains or losses. Any differences between interest received and paid under nonhedged swap agreements are reported with the change in fair value of the swaps as nonoperating gains or losses.

For interest rate swaps that are designated and qualify as cash flow hedges, the effective portion of the gains or losses resulting from changes in the fair value is reported as a component of unrestricted net assets. The ineffective portion, if any, is reported in excess of revenues over expenses in the current period. If hedging relationships cease to be highly effective, gains or losses on the interest rate swaps would be reported in excess of revenues over expenses and accumulated losses would be amortized into excess of revenues over expenses over the remaining life of the debt. Any differences between interest received and paid under the interest rate swap designated as a cash flow hedge is recorded as a component of interest expense. As of December 31, 2014, 2013, and 2012, the System does not have any swaps designated as cash flow hedges.

(e) Inventories

Inventories include drugs and supplies and are recorded at the lower of cost or market on a first-in, first-out (FIFO) basis.

(f) Bond Issue Costs

Costs of bond issuance are deferred and amortized on a straight-line basis over the shorter of the term of the related indebtedness or related liquidity facility.

(g) Investments in Unconsolidated Entities

Investments in entities in which the System has the ability to exercise significant influence over operating and financial policies but does not have operational control are recorded under the equity method of accounting and included in other assets in the consolidated balance sheets. The System's share of net earnings or losses of the entities is included in other operating revenue (note 8).

(h) Investments with Limited Uses

Investments with limited uses are reported at fair value and include assets held by trustees for repayment of long-term debt, assets in escrow for capital projects, assets held for self-insured professional and general liability claims, and donor-restricted funds.

(Dollars in thousands)

(i) Land, Buildings, and Equipment

Land, buildings, and equipment are carried at cost and depreciated using the straight-line method over their estimated useful lives. Interest cost, net of related interest income, incurred during the period for construction of capital assets is capitalized as a component of the cost of acquiring those assets and totaled $243, $744, and $925 for 2014, 2013, and 2012, respectively.

The following useful lives are used in computing depreciation:

Land improvements	5–25 years
Buildings	25–40 years
Building additions and improvements	10–20 years
Equipment	2–15 years

(j) Deferred Income Taxes

The System's taxable subsidiaries record deferred income taxes due to temporary differences between financial reporting and tax reporting for certain assets and liabilities. The System accounts for income taxes under the asset-and-liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled.

The System follows FASB Interpretation No. 48 (FIN 48), *Accounting for Uncertainty in Income Taxes – an interpretation of FASB Statement No. 109*, which clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements. This guidance is now included within Accounting Standards Codification (ASC) topic 740, *Income Taxes* (ASC 740). ASC 740 prescribes a more-likely-than-not recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken. Under ASC 740, tax positions will be evaluated for recognition, derecognition, and measurement using consistent criteria and will provide more information about the uncertainty in income tax assets and liabilities. As of December 31, 2014, 2013, and 2012, the System does not have any significant assets or liabilities recorded for uncertain tax benefits. The System has not recorded any reserves, or related accruals for interest and penalties for uncertain income tax positions.

(k) Professional and General Liability Claims

The System is insured for professional and general liability claims in excess of self-insured retention limits with an external insurance carrier.

(Continued)

(l) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors and are required to be maintained in perpetuity.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the System are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. Gifts are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets in the consolidated statements of operations and changes in net assets. In the absence of a donor specification that restricts income and gains on temporarily restricted gifts, such income and gains are reported as income of unrestricted net assets. In order to protect permanently restricted gifts from a loss of purchasing power, the System uses a spending-rate policy to determine the portion of investment return that can be used to support operations of the current period.

The System reports gifts of equipment or other long-lived assets as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the System reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service.

(n) Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients and third-party payers for services provided, including estimated retroactive adjustments due to audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as such revenue is no longer subject to such audits, reviews, and investigations.

The provisions for bad debts and charity care are based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. After satisfaction of amounts due from insurance, the System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System.

(o) Other Revenue

Other revenue includes income from investments in unconsolidated entities, rental income, pharmacy and ancillary sales, and grant revenue. Grant revenue includes Meaningful Use-Health Information

Technology for Economic and Clinical Health Act Stimulus Grants of $14,848, $23,515, and $20,443 for 2014, 2013, and 2012, respectively.

(p) Excess of Revenues over Expenses

Excess of revenues over expenses includes operating income and nonoperating gains and losses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments not classified as trading securities and interest rate swaps designated as cash flow hedges, and changes in liability relating to defined–benefit plans not marked to market.

(q) Investment Securities

The System classifies its investments as trading or available-for-sale. The available-for-sale investments include those held whose uses are limited. All other investments are classified as trading. Trading and available-for-sale investments, including bond funds and construction funds, are recorded at fair value. Investments in alternative investments are recorded at net asset value as a practical expedient to fair value. Unrealized gains and losses on trading securities are included in excess of revenues over expenses. Unrealized gains and losses on available-for-sale investments are excluded from excess of revenues over expenses and are reported as a separate component of other changes in unrestricted net assets.

(r) Fair Value Measurements

The System utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible. The System determines fair value based on assumptions that market participants would use in pricing an asset or liability in the principal or most advantageous market. When considering market participant assumptions in fair value measurements, the System follows the fair value hierarchy, as outlined in the fair value measurements and disclosures accounting guidance, which distinguishes between observable and unobservable inputs.

(3) Net Patient Service Revenue

The System has agreements with third-party payers who provide payments for health care services at amounts different from established rates. Payment arrangements include prospectively determined rates per discharge, discounted charges, and per diem payments. Other payments are received in the form of pay for performance, shared savings, care management, or medical home management per patient fees.

The System utilizes a process to identify and appeal certain settlements by Medicare and other third-party payers. Additional reimbursement is recorded in the year the appeal is successful. During 2014, 2013, and 2012, successful appeals, cost report settlements, and other adjustments to prior year estimates, including the rural floor budget neutrality adjustment and settlements related to revised Supplemental Security Income ratios for 2006 through 2011, resulted in an increase in net patient service revenue of $39,679, $16,648, and $50,003, respectively. The System recognizes significant amounts of patient service revenue at the time services are rendered even though it does not assess the patient's ability to pay. For uninsured patients who do not qualify for charity care, the System recognizes revenue on the basis of discounted

(Dollars in thousands)

rates. On the basis of historical experience, a significant portion of the System's patients will be unable or unwilling to pay for the services provided. Thus, the System records a significant provision for bad debts related to uninsured patients and self-pay balances of insured patients who are unable or unwilling to pay for the services provided. The System also records a provision for bad debts related to self-pay balances of insured patients. Patient service revenue net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period by major payer is as follows:

	2014	2013	2012
Medicare and Medicaid	39%	38%	38%
Managed care	55	57	57
Commercial and other	3	2	3
Self-pay	3	3	2
	100%	100%	100%

The System grants credit without collateral to its patients, most of whom are residents in the communities that it serves and are insured under third-party payer agreements. The System reduces its patient accounts receivable by an allowance for doubtful accounts. Deductibles and coinsurance are classified as either third-party or self-pay receivables on the basis of which party has the primary remaining financial responsibility, while the total gross revenue remains classified based on the primary payer at the time of service. In evaluating the collectibility 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 doubtful accounts and provision for bad debts. The System used a consistent methodology to estimate the allowance and provision for bad debts in the years 2014, 2013, and 2012. For receivables associated with self-pay patients after satisfaction of amounts due from insurance, the System follows established guidelines for charging off certain past-due patient balances against the allowance for doubtful accounts. The System has not changed its charity care or uninsured discount policies during the years 2014, 2013, or 2012. The System does not maintain an allowance for doubtful accounts from third-party payers, nor did it have significant write-offs from third-party payers. The mix of net patient accounts receivable by major payer as of December 31 consists of the following:

	2014	2013	2012
Medicare and Medicaid	34%	35%	34%
Managed care	42	42	40
Self-pay	16	12	14
Commercial and other	8	11	12
	100%	100%	100%

Two managed care payers accounted for approximately 36%, 36%, and 35% of net patient service revenue in 2014, 2013, and 2012, respectively. Amounts due from these two managed care payers accounted for approximately 25% of net patient accounts receivable at December 31, 2014, 2013, and 2012.

(Continued)

(4) Community Benefits

The System follows IRS reporting guidelines for categories of community benefit provided in the service areas of the System. The major components are defined below.

(a) Cost of Providing Charity Care (also referred to as Financial Assistance)

The System provides medical care without charge or at reduced cost to residents of the communities that it serves through the provision of charity care. Policies have been established to identify charity care cases that meet certain guidelines for a patient's ability to pay for services. The cost of providing charity care is measured by applying a cost-to-charge ratio to the charges identified as charity care.

(b) Costs in Excess of Medicaid Payments

The System provides services to public program enrollees (Medicaid). Such public programs typically reimburse at amounts less than cost.

(c) Medicaid Surcharge

The System is a participant in the Medicaid Surcharge program. The current program includes a 1.56% surcharge on a hospital's net patient service revenue (excluding Medicare revenue). Reported amounts are net of any disproportionate share adjustments.

(d) Costs of Other Means-tested Government Programs (MinnesotaCare Tax)

The System also participates in the funding of medical care for the uninsured through a MinnesotaCare tax of 2% on certain net patient service revenue. Patients who are unable to get insurance through their employer are eligible to participate in MinnesotaCare.

(e) Community Health Improvement Services

In the furtherance of its charitable purpose, the System provides a wide variety of community health improvement programs and activities to the various communities that it serves in response to specific needs within those communities. Examples are programs and activities designed to improve the quality of life and build healthier communities. Community services activities include social service programs, health screenings, in-home caregiver services, support counseling for patients and families, crisis intervention, health enhancement and wellness programs, classes on specific conditions, and telephone information services. The System provides these services through programs such as the Backyard Initiative; Free Bikes 4 Kidz; New Shoes, Healthy Kids; Neighborhood Health Connection; Health Powered Kids; and Change to Chill.

(f) Subsidized Health Services

The System provides necessary health care services, which include 24-hour emergency services to the community and behavioral health services. These clinical services are provided despite financial losses so significant that negative margins remain after removing the effects of charity care, Medicaid shortfalls, and bad debt. These services are provided because they meet an identified

community need and, if no longer offered, would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide.

(g) Health Profession Education

The System provides education and training programs and financial assistance for providers, health care students, and other health professionals.

(h) Research

The System participates in clinical and community health research that is shared with the health care community, including clinical research related to integrative medicine and cancer interventions as well as community health research related to care model innovations and population health. Beginning January 1, 2014, research costs are reported net of restricted grants designated and released for research purposes.

(i) Cash and In-Kind Contributions

The System donates funds and in-kind services to individuals and or the community at large and other not-for-profit organizations. Examples are the donation of space for use by community groups, event sponsorships, donation of food, equipment and supplies, and grants.

(j) Other Community Benefit Cost

The System allocates staff time to manage community benefit reporting, assess community benefit programs and needs, and develop and implement programs and activities in response to those needs.

The System contributes additional resources to the communities in which it provides services. The major components are defined below:

Costs in Excess of Medicare Payments – The System provides services to public program enrollees (Medicare). Such public programs typically reimburse at amounts less than cost.

Other Care Provided without Compensation (Bad Debt) – The System provides medical care in which charges are uncollected beyond what is provided under the definition of charity care.

Discounts Offered to Uninsured Patients – The hospitals in the System provide a discount on billed charges for medically necessary care delivered to patients who are uninsured and ineligible for government programs or otherwise medically indigent. The unbilled portion of uninsured care is excluded from net patient service revenue.

Taxes and Fees – The System pays property taxes to local and state government used in funding civil and education services to the community.

Community Building – The System engages in community activities that address root causes of health problems such as poverty, homelessness, and environmental issues by participating in

(Dollars in thousands)

activities including economic development work, workforce development, public safety efforts, and community health improvement work.

The following is an estimate of the community benefits provided by the System:

	2014	2013	2012
Cost of providing charity care (charges forgone of $50,623, $74,083, and $80,384, respectively)	$ 21,400	29,500	30,400
Costs in excess of Medicaid payments	57,300	53,900	53,400
Medicaid surcharge	25,500	23,100	21,600
MinnesotaCare tax	45,500	42,800	41,100
Community health improvement services	9,100	8,600	9,000
Subsidized health services	3,800	2,600	2,500
Health professions education	25,300	23,800	23,100
Research	4,800	15,800	10,500
Cash and in-kind contributions	2,600	3,000	3,500
Other community benefit cost	4,900	5,100	4,400
Total cost of community benefit	200,200	208,200	199,500
Costs in excess of Medicare payments	168,500	189,500	156,900
Other care provided without compensation (bad debt)	93,500	90,500	76,200
Discounts offered to uninsured patients	32,600	46,500	39,200
Taxes and fees	4,600	6,300	5,600
Community building	800	400	700
Total value of community contributions	$ 500,200	541,400	478,100

(5) Cash and Cash Equivalents and Investments

As of December 31, cash and cash equivalents and investments, including those with limited uses, consist of the following:

	2014	2013	2012
Cash and cash equivalents	$ 180,985	132,704	147,405
Money market collective fund and short-term fixed income	114,118	165,233	66,414
Fixed income	864,850	665,229	564,324
Equity securities	290,046	369,187	205,080
Investments accounted for at net asset value	419,193	391,276	592,675
	$ 1,869,192	1,723,629	1,575,898

(Continued)

(Dollars in thousands)

Certain investments are held for the following limited uses as of December 31:

		2014	2013	2012
By trustee for repayment of long-term debt	$	52	2,193	2,765
By trustee for swap collateralization		6,750	—	13,640
In escrow for capital projects		13	26	25
Donor-restricted funds		139,792	139,525	105,004
Self-insured professional and general liability claims		3,555	10,811	10,105
	$	150,162	152,555	131,539

Total investment return consists of the following:

		2014	2013	2012
Investment earnings in unrestricted net assets:				
Interest and dividend income (net of expense of $1,397, $1,125, and $932 for 2014, 2013, and 2012, respectively)	$	21,925	17,512	16,181
Realized gains on investments		14,278	88,915	2,731
Unrealized gains (losses) on investments		10,787	(13,444)	69,801
		46,990	92,983	88,713
Investment earnings in restricted net assets:				
Interest and dividend income		1,684	1,189	1,163
Realized gains on investments		2,470	7,866	422
Unrealized gains on investments		240	331	6,116
		4,394	9,386	7,701
	$	51,384	102,369	96,414

Total investment return is reported in the consolidated statements of operations and changes in net assets as follows:

		2014	2013	2012
Nonoperating gains	$	46,990	92,983	88,713
Changes in restricted net assets		4,394	9,386	7,701
	$	51,384	102,369	96,414

(Continued)

(Dollars in thousands)

(6) Other Current Assets

Other current assets as of December 31 consist of the following:

	2014	2013	2012
Pledges and notes receivable	$ 7,266	5,598	8,732
Prepaid expenses	20,184	10,475	9,194
Other miscellaneous receivables	81,939	59,053	42,543
	$ 109,389	75,126	60,469

(7) Land, Buildings, and Equipment

Land, buildings, and equipment as of December 31 consist of the following:

	2014	2013	2012
Land and land improvements	$ 95,488	94,497	79,475
Buildings	1,316,725	1,264,600	1,146,387
Equipment	1,410,022	1,366,368	1,292,383
	2,822,235	2,725,465	2,518,245
Less accumulated depreciation and amortization	1,820,356	1,727,334	1,639,216
	1,001,879	998,131	879,029
Construction in progress	40,071	52,639	77,747
	$ 1,041,950	1,050,770	956,776

(8) Other Assets

Other assets as of December 31 consist of the following:

	2014	2013	2012
Cash surrender value of insurance policies	$ 4,422	4,461	4,116
Pledges and notes receivable, less current portion	23,753	18,853	16,065
Investment in unconsolidated entities	54,788	52,380	46,717
Deferred bond issuance costs, net	3,923	4,133	4,542
Deferred compensation	136,308	120,426	98,690
Other	23,359	25,344	6,602
	$ 246,553	225,597	176,732

(Continued)

(Dollars in thousands)

The following table represents the System's investment in and share of net earnings of unconsolidated entities recorded under the equity method of accounting as of and for the years ended December 31:

	Percentage ownership	Equity investment			Share of net earnings		
		2014	2013	2012	2014	2013	2012
St. Francis Regional Medical Center	37.40%	$ 34,156	30,283	25,930	3,873	4,353	4,275
Other entities	16% – 50%	20,632	22,097	20,787	9,115	10,989	7,565
		$ 54,788	52,380	46,717	12,988	15,342	11,840

The following table reflects summarized financial information for St. Francis Regional Medical Center as of and for the years ended December 31:

	2014	2013	2012
Total assets	$ 156,742	165,590	162,854
Total liabilities	70,354	74,296	75,428
Total net assets	86,388	91,294	87,426
Total revenue	125,894	120,928	120,719
Total operating expenses	116,086	112,365	111,113
Total investment return and other nonoperating	268	3,753	3,169
Excess of revenues over expenses	10,076	12,316	12,775

(9) Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses as of December 31 consist of the following:

	2014	2013	2012
Outstanding checks	$ 57,746	54,137	62,202
Trade accounts payable	44,361	57,492	43,063
Accrued payroll, taxes, and vacation	186,183	171,431	161,526
Other	139,895	137,056	125,114
	$ 428,185	420,116	391,905

(Continued)

(Dollars in thousands)

(10) Other Current Liabilities

Other current liabilities as of December 31 consist of the following:

	2014	2013	2012
Current portion of estimated reserves for professional and general liability claims	$ 12,354	12,762	12,981
Current portion of estimated reserves for workers' compensation claims	13,911	13,138	13,217
Employee health plan claims incurred but not reported	16,498	14,094	17,218
Defined–contribution retirement plan	38,650	35,800	34,519
Due to third-party payers	—	1,976	1,762
Current portion of long-term debt	20,347	39,368	39,069
	$ 101,760	117,138	118,766

(Continued)

(Dollars in thousands)

(11) Long-Term Debt

Long-term debt as of December 31 consists of the following:

	2014	2013	2012
Fixed Rate Revenue Bonds, Series 2009A-1 (Allina Health System), annual interest rate from 4.50% to 5.25%	$ 106,415	108,015	109,515
Fixed Rate Revenue Bonds, Series 2009A-2 (Allina Health System), annual interest rate from 3.25% to 5.5%	68,860	71,145	71,430
Variable Rate Revenue Bonds, Series 2009B&C (Allina Health System), Variable Rate Demand Notes, average annual interest rate of 0.04% during 2014; 0.02% at December 31, 2014	164,525	164,525	164,525
Fixed Rate Revenue Bonds, Series 2007A (Allina Health System), annual interest rate from 4.50% to 5.50%	105,415	111,565	117,550
Variable Rate Revenue Bonds, Series 2007C (Allina Health System), Variable Rate Demand Notes, average annual interest rate of 0.05% during 2014; 0.03% at December 31, 2014	121,250	121,950	122,625
Variable Rate Revenue Bonds, Series 1998A (Allina Health System) Periodic Auction Reset, average annual interest rate of 0.10% during 2014; 0.10% at December 31, 2014	14,575	18,875	24,925
Variable Rate Health Care System Revenue Bonds, Series 1993B (HealthSpan) Periodic Auction Reset, average annual interest rate of 0.08% during 2014; 0.06% at December 31, 2014	24,900	26,100	27,400
Variable Rate Demand Hospital Revenue Bonds, Series 1985 (Health Central), average annual interest rate of 0.06% during 2014	—	3,400	5,700

(Continued)

(Dollars in thousands)

	2014	2013	2012
Fixed-Rate Health Facilities Revenue Bonds, Series 1994A	$ —	—	9,990
Variable Rate Taxable Bonds, Series 1994B (WestHealth)	—	—	10,400
Fixed Rate Health Care Facilities Revenue Note, Series 2014 (Allina Health System), annual interest rate of 2.55%	20,165	—	—
Line of Credit	—	19,965	—
Capitalized leases	4,053	4,622	5,208
Other	163	201	221
	630,321	650,363	669,489
Unamortized portion of original issue premium	3,320	3,811	4,302
Current portion	(20,347)	(39,368)	(39,069)
	$ 613,294	614,806	634,722

Certain divisions of the System are members of the Allina Obligated Group (Obligated Group), which is subject to the terms and conditions of the Master Trust Indenture dated October 1, 1998, as amended, between the System and Wells Fargo Bank Minnesota, National Association, and is jointly and severally liable for any debts and/or other obligations of each Obligated Group member and the Obligated Group as a whole. The Obligated Group members include the hospitals, nonhospital specialty care services, and certain physician clinics. The System also operates several wholly owned direct and indirect subsidiaries outside of the Obligated Group, including clinics and foundations.

In December 2014, the City of Minneapolis, on behalf of the System, issued a fixed-rate Revenue Note, Series 2014, in the aggregate principal amount of $20,165. The 2014 Revenue Note is secured by the Obligated Group's pledged revenue and was used to pay off the portion of the System's line of credit relating to the refinancing of the Regina Medical Center 2010 Series Bond.

In June 2011, through an acquisition, the System assumed a fixed-rate mortgage payable, the fixed-rate Revenue Bonds, Series 1994A, issued by the City of Plymouth, on behalf of WestHealth and the variable rate WestHealth Taxable Bonds, Series 1994B, issued pursuant to an Indenture of Trust. The mortgage payable had a balloon payment due in August 2012, and was fully repaid in May 2012. The 1994A and 1994B Bonds were paid in full on January 15, 2013, and are classified as current portion of long-term debt at December 31, 2012. The 1994B Bonds were secured through a bank under a Standby Bond Purchase Agreement (the Agreement), which terminated on January 15, 2013 with payment of the bonds. Under the Agreement, the bank had committed to purchase bonds if put and not remarketed. There were no draws over the life of the agreement.

In November 2009, the City of Minneapolis and the Housing and Redevelopment Authority of the City of Saint Paul, on behalf of the System, issued fixed-rate Revenue Bonds, Series 2009A-1 and 2009A-2, in the aggregate principal amount of $113,415 and $71,830, respectively. In addition, Variable Rate Revenue

Bonds, Series 2009B&C, were issued in the aggregate amount of $164,525. The 2009A-1 Bonds are secured by the Obligated Group's pledged revenue and were used to acquire, construct, and renovate certain of the System's facilities and refinance and legally defease, in part, the 2007B Bonds. The 2009A-2 Bonds are secured by the Obligated Group's pledged revenue and were used to redeem, in part, the Series 1998A Variable Rate Revenue Bonds at a redemption price of 93%. The 2009B&C Bonds are secured by the Obligated Group's pledged revenue and were used to refinance and legally defease the remaining portion of the Series 2007B Variable Rate Revenue Bonds not refinanced through the issuance of the 2009A-1 Bonds.

The Series 2009B&C Bonds are secured by letters of credit issued by two banks. Repayment of draws against the letters is secured by term credit agreements with the banks in the amount of $114,525, which expires on January 5, 2017, and $50,000, which expires on January 4, 2017. If the bonds were put and not remarketed, the banks would be required to purchase the bonds. Draws under the term credit agreements to repay the banks for the purchase of the bonds are payable in an amount equal to the principal payments necessary to repay the draws over five years in equal quarterly installments, beginning 367 days after the draw, based on the bank's base rate plus 2.00%.

Payment of principal and interest on the Series 2007A, Series 1998A, and Series 1993B Bonds is insured. Interest rates on the variable rate Series 1998A and Series 1993B Bonds are determined by auction. If an auction fails, interest rates payable to the existing bondholders are determined by a formula incorporated in the bond documents for these two series of bonds.

The Series 1985 Bonds were paid in full on December 1, 2014. The 1985 Bonds were secured by a letter of credit issued by a bank, which terminated on December 1, 2014 with the payment of the bonds. Under the agreement, the bank had committed to purchase the bonds if put and not remarketed. There were no draws over the life of the agreement.

On June 18, 2008, the System completed a conversion of the Series 2007C Bonds from auction rate securities to variable rate demand bonds. This conversion included the insurer's consent to remove the insurance and for a bank to support the bonds with a direct pay letter of credit. Repayment of draws against the letter is secured by a term credit agreement with the bank in the aggregate amount of $121,950, which expires on January 4, 2017. If the bonds were put and not remarketed, the bank would be required to purchase the bonds. Draws under the term credit agreement to repay the bank for the purchase of the bonds are payable in an amount equal to the principal payments necessary to repay the draws over five years, beginning 367 days after the draw, based on the bank's base rate plus 2.00%.

In September 2013, through an acquisition, the System assumed the fixed rate Revenue Bonds, Series 2010, issued by the City of Hastings, on behalf of Regina Medical Center. In December 2013, the System utilized its line of credit with a bank in the amount of $19,965, respectively, to pay off the Series 2010 Bond, which was classified in current portion of long-term debt at December 31, 2013. The draw was paid in full in December 2014 with the issuance of the Series 2014 Revenue Note.

(Dollars in thousands)

Aggregate annual maturities of long-term debt and mandatory sinking fund requirements, as stated under the actual debt terms, for each of the five years following December 31, 2014, are as follows:

2015	$	20,347
2016		22,024
2017		22,674
2018		23,523
2019		24,761
Thereafter		516,992

Aggregate principal payments of long-term debt based on the variable rate demand notes being put back to the System and a corresponding draw being made on underlying liquidity facilities, for each of the five years following December 31, 2014, are as follows:

2015	$	20,347
2016		78,379
2017		79,254
2018		79,853
2019		81,066
Thereafter		291,422

The System uses interest rate swaps as a part of its risk management strategy to manage exposure to fluctuations in interest rates and to manage the overall cost of its debt. Four of the five interest rate swaps are used to hedge identified debt, or interest rate exposures, and are not used for speculative purposes. One of the interest rate swaps was established for speculative purposes and is not tied directly to outstanding debt. Interest rate swaps are recognized as either other long-term assets or other long-term liabilities in accordance with the netting provisions in the counterparty agreement and are measured at fair value.

(Continued)

(Dollars in thousands)

As of December 31, 2014, the System posted collateral of $6,750, related to one of the System's swaps due to changes in interest rates. As of December 31, 2013, the System had no collateral posted. As of December 31, 2012, the System posted collateral of $13,640, related to two of the System's swaps due to changes in interest rates. The following table provides details regarding the System's fair value of the derivative instruments at December 31, 2014, none of which are designated as cash flow hedging instruments:

		Fixed payer interest rate swaps					
Swap	Balance sheet location	Fair value	Notional amount outstanding	Rate paid	Rate received	Average rate received in 2014	Counterparty
2009BC	Other liabilities	$ 11,139	41,131	3.74%	% of LIBOR	0.45%	Wells Fargo
2009BC	Other liabilities	33,331	123,394	3.73	% of LIBOR	0.45	JP Morgan
2007C	Other liabilities	26,400	121,250	3.58	% of LIBOR	0.35	US Bank
2001	Other liabilities	17,445	50,000	5.17	SIFMA	0.05	Goldman Sachs
1998A	Other liabilities	2,534	15,075	4.44	SIFMA	0.05	Goldman Sachs
Total		$ 90,849	350,850				

The following table provides details regarding the System's fair value of the derivative instruments at December 31, 2013, none of which are designated as cash flow hedging instruments:

		Fixed payer interest rate swaps					
Swap	Balance sheet location	Fair value	Notional amount outstanding	Rate paid	Rate received	Average rate received in 2013	Counterparty
2009BC	Other liabilities	$ 7,195	41,131	3.74%	% of LIBOR	0.47%	Wells Fargo
2009BC	Other liabilities	21,407	123,394	3.73	% of LIBOR	0.47	JP Morgan
2007C	Other liabilities	17,924	121,950	3.58	% of LIBOR	0.37	UBS
2001	Other liabilities	12,461	50,000	5.17	SIFMA	0.09	Goldman Sachs
1998A	Other liabilities	2,589	19,375	4.44	SIFMA	0.09	Goldman Sachs
Total		$ 61,576	355,850				

The following table provides details regarding the System's fair value of the derivative instruments at December 31, 2012, none of which are designated as cash flow hedging instruments:

		Fixed payer interest rate swaps					
Swap	Balance sheet location	Fair value	Notional amount outstanding	Rate paid	Rate received	Average rate received in 2012	Counterparty
2009BC	Other liabilities	$ 11,848	41,131	3.74%	% of LIBOR	0.50%	Wells Fargo
2009BC	Other liabilities	35,455	123,394	3.73	% of LIBOR	0.50	JP Morgan
2007C	Other liabilities	29,846	122,625	3.58	% of LIBOR	0.40	UBS
2001	Other liabilities	19,721	50,000	5.17	SIFMA	0.16	Goldman Sachs
1998A	Other liabilities	3,966	23,475	4.44	SIFMA	0.16	Goldman Sachs
Total		$ 100,836	360,625				

(Continued)

(Dollars in thousands)

The following table provides details regarding the gains (losses) from the System derivative instruments in the consolidated statements of operations and changes in net assets, none of which are currently designated as hedging instruments. The 1998A swap was designated as a hedging instrument until December 31, 2008.

	Amount of gain (loss) on change in fair value recognized as nonoperating: gains (losses) on interest rate swap agreements			Amount of loss reclassified from unrestricted net assets into revenues over expenses as nonoperating: gains (losses) on interest rate swap agreements			Amount of interest paid to counterparty recognized as nonoperating: gains (losses) on interest rate swap agreements			Total		
	2014	2013	2012	2014	2013	2012	2014	2013	2012	2014	2013	2012
2009BC	$ (15,868)	18,701	1,310	—	—	—	(5,409)	(5,363)	(5,352)	(21,277)	13,338	(4,042)
2007C	(8,476)	11,922	290	—	—	—	(3,921)	(3,917)	(3,923)	(12,397)	8,005	(3,633)
2001	(4,984)	7,260	(949)	—	—	—	(2,551)	(2,526)	(2,518)	(7,535)	4,734	(3,467)
1998A	55	1,377	87	(874)	(874)	(874)	(772)	(946)	(1,100)	(1,591)	(443)	(1,887)
	$ (29,273)	39,260	738	(874)	(874)	(874)	(12,653)	(12,752)	(12,893)	(42,800)	25,634	(13,029)

The System records the swaps' liability at fair value, which requires nonperformance risk (i.e., credit risk), to be included in the valuation. Nonperformance risk is defined as the risk that the obligation will not be fulfilled and affects the value at which the liability is transferred. This nonperformance risk is determined by adjusting the discounting rate by a credit spread as of the reporting date. The addition of the credit spread to the discounting rate reduces the reported liability. Because of market volatility, the fair value reported liability of the swaps is approximately $6,724, $1,916, and $8,665 less as of December 31, 2014, 2013, and 2012, respectively, than the mark-to-market valuations (note 14).

The estimated fair value of long-term debt was $666,198, $676,238, and $708,909 as of December 31, 2014, 2013, and 2012, respectively. Interest rates that are currently available to the System for issuance of debt with similar terms and remaining maturities are used to estimate the fair value of fixed-rate debt through the use of discounted cash flow analyses. The fair value measurement was done using Level 2 criteria (note 14). The carrying amount of variable rate bonds and other notes payable approximates fair value.

Interest paid, net of amounts capitalized, was $16,330, $16,467, and $16,947 during 2014, 2013, and 2012, respectively.

The System has a Revolving Credit Agreement with Wells Fargo Bank through June 17, 2019, which consists of a line of credit of $26,000. The interest rate on the line of credit is the Reserve Adjusted London Interbank Offered Rate (LIBOR) plus 0.5%, and is secured by a note under the 1998 Master Trust Indenture. The unused line fee for the revolving line of credit is 0.15% per annum. In December 2013, the System had a draw of $19,965, respectively, on the line of credit to pay off the Regina Medical Center 2010 Series Bond, which was classified in current portion long-term debt at December 31, 2013. The draw was paid in December 2014 with the Series 2014 Revenue Note. The System also had insurance-related letters of credit applied against the line of credit in the amount of $2,536, $4,036, and $3,150 at December 31, 2014, 2013, and 2012, respectively.

(Dollars in thousands)

(12) Other Liabilities

Other liabilities as of December 31 consist of the following:

	2014	2013	2012
Estimated reserves for professional and general liability claims, less current portion	$ 42,498	57,462	59,937
Estimated reserves for workers' compensation claims, less current portion	30,005	27,660	30,115
Net pension and postretirement liability	20,591	12,500	59,257
Interest rate swaps payable	90,849	61,576	100,836
Deferred compensation	165,052	147,212	125,212
Leasehold incentive allowance	22,455	20,910	16,750
Financing obligation	25,624	25,624	25,624
Other	23,471	16,965	8,362
	$ 420,545	369,909	426,093

(13) Restricted Net Assets

Temporarily restricted net assets have been restricted by donors for the following purposes as of December 31:

	2014	2013	2012
Capital	$ 17,147	11,032	18,300
Charity and indigent care	4,712	4,454	4,132
Education and research	22,061	19,761	16,572
Patient care	20,232	18,405	17,997
Other	51,003	45,273	32,535
	$ 115,155	98,925	89,536

Income on the following permanently restricted net assets is restricted for the following purposes as of December 31:

	2014	2013	2012
Capital	$ 128	128	77
Charity and indigent care	1,806	1,806	1,806
Education and research	18,644	18,371	18,020
Patient care	12,710	12,710	11,772
Other	21,660	22,018	14,106
	$ 54,948	55,033	45,781

(Continued)

(14) Fair Value Measurements

The System's investments include money market, fixed income, and equity securities, which are carried at fair value based on quoted market prices and are classified as trading securities. Investment securities are exposed to various risks, such as interest rate, credit, and overall market volatility. In addition, the System invests in limited partnerships that hold interests in hedge funds, private equity, emerging markets, debt, and commodities, which are accounted for at net asset value as a practical expedient to fair value, and the System recognizes the increase or decrease in the partnerships' net asset value in nonoperating gains (losses). The System generally has liquidity ranging from 30 to 90 days in these funds. Certain of the underlying partnerships may hold some securities without readily determinable fair values.

For all financial instruments other than investments, derivatives, and long-term debt (note 11), the carrying value is a reasonable estimate of fair value because of the short-term nature of the financial instruments.

Realized gains and losses on investments, interest, dividends, and declines in investment value determined to be other than temporary are recorded as nonoperating gains (losses) unless the investment return is restricted by donor or law. Changes in unrealized gains and losses that are considered temporary are recorded as nonoperating gains (losses) for investments classified as trading and as other changes in unrestricted net assets for investments classified as other-than-trading. Investment return restricted by donor or law is recorded as changes in restricted net assets.

The System determines the fair value of its financial instruments based on the fair value hierarchy established in ASC Topic 820, *Fair Value Measurement*, which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value.

> Level 1 Inputs: Quoted prices in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date.
>
> Level 2 Inputs: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly through corroboration with observable market data.
>
> Level 3 Inputs: Unobservable inputs for the asset or liability, that is, inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing an asset or liability (including risk assumptions) developed based on the best information available in the circumstances.

Inputs and valuation techniques for significant other observable and significant unobservable inputs are as follows:

For Level 2 and Level 3 cash equivalents and fixed income assets that rely on significant other observable inputs and significant unobservable inputs, the System employs multiple third-party information providers to help determine the fair value of the assets. Level 2 and Level 3 securities in separately managed accounts are held at Bank of New York Mellon (BNYMellon), who acts as Trustee and Custodian for the assets. As Custodian, BNYMellon uses multiple pricing services to value the assets. The investment managers utilize their own pricing services and valuation processes. Any significant discrepancies between

(Dollars in thousands)

Custodian and investment manager values are reconciled on a monthly basis by the managers and BNYMellon. The System also employs an investment consultant who researches significant pricing differences between the manager and custodian on a security-by-security basis. The consultant will notify the Custodian of any significant pricing issues.

For Level 2 and Level 3 funds of hedge funds, limited partnership assets, and commingled monthly valued funds, the System utilizes net asset value per share or its equivalent to determine the fair value of the assets. For Level 2, the System has the ability to redeem its investment with the investee at net asset value per share (or its equivalent) at the measurement date.

The System's financial assets and liabilities that are measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2014 as follows:

		Fair value measurements using		
	Total	**Level 1**	**Level 2**	**Level 3**
Cash and cash equivalents:				
Cash	$ 17,971	17,971	—	—
Money market funds	163,014	163,014	—	—
Total cash and cash equivalents	180,985	180,985	—	—
Short-term and long-term investments – trading securities:				
Short-term fixed income	56,498	54,040	2,458	—
Money market fund	28,866	28,866	—	—
Total short-term fixed income and money market	85,364	82,906	2,458	—
Equity:				
Financials	16,354	16,354	—	—
Consumer	8,269	8,269	—	—
Industrials	9,466	9,466	—	—
Technology	2,556	2,556	—	—
Healthcare	2,481	2,481	—	—
International equity mutual funds	217,622	217,622	—	—
Other equity	11,013	7,841	3,172	—
Total equity	267,761	264,589	3,172	—
Fixed income:				
U.S. Treasury securities	173,208	173,208	—	—
U.S. Agency securities	99,722	—	99,722	—
Corporate bonds	136,122	—	136,122	—

(Continued)

(Dollars in thousands)

	Total	Fair value measurements using Level 1	Level 2	Level 3
Mortgage, commercial, and asset-backed securities	$ 100,963	—	100,963	—
Sovereigns	5,456	—	5,456	—
Term loan/private placement	44,841	—	43,783	1,058
All asset mutual fund	94,719	94,719	—	—
Other	142,904	123,915	18,989	—
Total fixed income	797,935	391,842	405,035	1,058
Investments accounted for at net asset value:				
Global bonds fund	58,388	—	58,388	—
Global equity fund	71,614	—	71,614	—
Emerging markets equity fund	30,828	—	30,828	—
Equity long/short hedge funds	63,449	—	63,449	—
Opportunistic fixed income hedge funds	82,452	—	82,452	—
Fund of hedge funds	1,609	—	13	1,596
Private equity funds	24,929	—	—	24,929
Emerging market debt fund	53,716	—	53,716	—
Total investments accounted for at net asset value	386,985	—	360,460	26,525
Total investments – trading securities	1,538,045	739,337	771,125	27,583
Investments with limited uses – trading securities:				
Short-term fixed income	13,967	13,847	120	—
Money market collective fund	14,776	14,776	—	—
Equity	22,285	22,021	264	—
Fixed income	56,509	29,194	27,227	88
Investments accounted for at net asset value	32,208	—	30,000	2,208
Restricted foundation trusts (fixed income)	10,406	—	10,406	—
Total investments with limited uses – trading securities	150,151	79,838	68,017	2,296

(Continued)

(Dollars in thousands)

		Total	Fair value measurements using Level 1	Level 2	Level 3
Investments with limited uses – available-for-sale securities:	$				
Money market fund		11	11	—	—
Total investments with limited uses		150,162	79,849	68,017	2,296
Total	$	1,869,192	1,000,171	839,142	29,879
Liabilities:					
Interest rate swaps	$	90,849	—	90,849	—

		Fair value measurements, Level 3 Total	Term loan	Hedge funds	Private equity
Balance, December 31, 2013	$	12,029	218	2,448	9,363
Total realized and unrealized losses included in excess of revenues over expenses		2,700	(34)	98	2,636
Purchases		18,887	1,299	—	17,588
Sales		(3,737)	(337)	(817)	(2,583)
Balance, December 31, 2014	$	29,879	1,146	1,729	27,004

There were no significant transfers in or out of Level 1, Level 2, or Level 3 securities during the years ended December 31, 2012, 2013, and 2014.

(Continued)

(Dollars in thousands)

The System's financial assets and liabilities that are measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2013 as follows:

	Total	Fair value measurements using Level 1	Level 2	Level 3
Cash and cash equivalents:				
Cash	$ 28,797	28,797	—	—
Money market funds	103,907	103,907	—	—
Total cash and cash equivalents	132,704	132,704	—	—
Short-term and long-term investments – trading securities:				
Short-term fixed income	121,404	121,218	186	—
Money market fund	3,365	3,365	—	—
Total short-term fixed income and money market	124,769	124,583	186	—
Equity:				
Financials	14,006	14,006	—	—
Consumer	6,007	6,007	—	—
Industrials	10,084	10,084	—	—
Technology	7,100	7,100	—	—
Healthcare	2,505	2,505	—	—
International equity mutual funds	222,882	222,882	—	—
Other equity	78,030	78,030	—	—
Total equity	340,614	340,614	—	—

(Continued)

(Dollars in thousands)

		Fair value measurements using		
	Total	**Level 1**	**Level 2**	**Level 3**
Fixed income:				
U.S. Treasury securities	$ 158,206	158,206	—	—
U.S. Agency securities	128,227	—	128,227	—
Corporate bonds	116,217	—	116,217	—
Mortgage, commercial, and asset-backed securities	91,826	—	91,826	—
Sovereigns	3,781	—	3,781	—
Term loan/private placement	35,891	—	35,690	201
Other	77,845	63,306	14,539	—
Total fixed income	611,993	221,512	390,280	201
Investments accounted for at net asset value:				
Global bonds fund	55,536	—	55,536	—
Global equity fund	65,869	—	65,869	—
Emerging markets equity fund	29,834	—	29,834	—
Equity long/short hedge funds	48,975	—	48,975	—
Opportunistic fixed income hedge funds	74,456	—	74,456	—
Fund of hedge funds	4,328	—	2,069	2,259
Private equity funds	8,638	—	—	8,638
Emerging market debt fund	53,367	—	53,367	—
Commodities	19,991	—	19,991	—
Total investments accounted for at net asset value	360,994	—	350,097	10,897
Total investments – trading securities	1,438,370	686,709	740,563	11,098
Investments with limited uses – trading securities:				
Short-term fixed income	15,657	15,647	10	—
Money market collective fund	21,186	—	21,186	—
Equity	28,573	28,573	—	—
Fixed income	43,485	15,974	27,494	17
Investments accounted for at net asset value	30,282	—	29,368	914
Restricted foundation trusts (fixed income)	9,751	—	9,751	—
Total investments with limited uses – trading securities	148,934	60,194	87,809	931

(Continued)

(Dollars in thousands)

		Total	Fair value measurements using Level 1	Level 2	Level 3
Investments with limited uses – available-for-sale securities:					
Money market fund	$	2,163	2,163	—	—
U.S. agency securities		1,458	—	1,458	—
Total investments with limited uses – available-for-sale securities		3,621	2,163	1,458	—
Total investments with limited uses		152,555	62,357	89,267	931
Total	$	1,723,629	881,770	829,830	12,029
Liabilities:					
Interest rate swaps	$	61,576	—	61,576	—

		Fair value measurements, Level 3 Total	Term loan	Hedge funds	Private equity
Balance, December 31, 2012	$	3,867	—	3,867	—
Total realized and unrealized losses included in excess of revenues over expenses		1,730	2	240	1,488
Purchases		10,029	217	—	9,812
Sales		(3,597)	(1)	(1,659)	(1,937)
Balance, December 31, 2013	$	12,029	218	2,448	9,363

(Continued)

(Dollars in thousands)

The System's financial assets and liabilities that are measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2012 as follows:

	Total	Fair value measurements using Level 1	Level 2	Level 3
Cash and cash equivalents:				
Cash	$ 38,403	38,403	—	—
Money market funds	109,002	109,002	—	—
Total cash and cash equivalents	147,405	147,405	—	—
Short-term and long-term investments – trading securities:				
Short-term fixed income	37,491	37,491	—	—
Money market collective fund	2,137	—	2,137	—
Total short-term fixed income and money market	39,628	37,491	2,137	—
Equity:				
Financials	10,556	10,556	—	—
Consumer	4,381	4,381	—	—
Industrials	8,672	8,672	—	—
Technology	2,796	2,796	—	—
Healthcare	751	751	—	—
International equity mutual funds	156,705	156,705	—	—
Other equity	5,639	5,639	—	—
Total equity	189,500	189,500	—	—
Fixed income:				
U.S. Treasury securities	114,219	114,219	—	—
U.S. Agency securities	96,399	—	96,399	—
Corporate bonds	126,707	—	126,707	—
Mortgage, commercial, and asset-backed securities	99,581	—	99,581	—
Sovereigns	5,831	—	5,831	—
Term loan/private placements	26,274	—	26,274	—
Other	51,165	43,839	7,326	—
Total fixed income	520,176	158,058	362,118	—
Investments accounted for at net asset value:				
TIPS fund	30,956	—	30,956	—
Global bonds fund	42,665	—	42,665	—
Global equity fund	51,660	—	51,660	—

(Continued)

(Dollars in thousands)

		Total	Fair value measurements using Level 1	Level 2	Level 3
Emerging markets equity fund	$	23,556	—	23,556	—
Equity long/short fund of hedge funds		180,638	—	180,638	—
Multistrategy fund of hedge funds		183,230	—	179,657	3,573
Commodities		34,945	—	34,945	—
Total investments accounted for at net asset value		547,650	—	544,077	3,573
Total investments – trading securities		1,296,954	385,049	908,332	3,573
Investments with limited uses – trading securities:					
Short-term fixed income		22,970	22,970	—	—
Money market collective fund		1,654	—	1,654	—
Equity		15,580	15,580	—	—
Fixed income		39,720	12,134	27,586	—
Investments accounted for at net asset value		45,025	—	44,731	294
Restricted foundation trusts		4,428	—	4,428	—
Total investments with limited uses – trading securities		129,377	50,684	78,399	294
Investments with limited uses – available-for-sale securities:					
Money market fund		2,162	2,162	—	—
Total investments with limited uses – available-for-sale securities		2,162	2,162	—	—
Total investments with limited uses		131,539	52,846	78,399	294
Total	$	1,575,898	585,300	986,731	3,867
Liabilities:					
Interest rate swaps	$	100,836	—	100,836	—

(Continued)

(Dollars in thousands)

		Fair value measurements, Level 3		
		Total	**Term loan**	**Hedge funds**
Balance, December 31, 2011	$	6,546	191	6,355
Total realized and unrealized losses included in excess of revenues over expenses		(274)	(5)	(269)
Purchases		—	—	—
Sales		(2,405)	(186)	(2,219)
Balance, December 31, 2012	$	3,867	—	3,867

Level 3 pricing is based on net asset value or ownership values provided by hedge fund managers who obtain the net asset value or ownership values from the underlying managers in which they invest.

Fair value measurements of investments in certain entities that calculate net asset value per share (or its equivalent), including restricted and unrestricted assets, as of December 31, 2014 are as follows:

		Net asset value	**Unfunded commitments**	**Redemption frequency (if currently eligible)**	**Redemption notice period**
Global bonds fund	$	63,248	—	Monthly	15 days
Global equity fund		77,575	—	45 days	15 days
Emerging markets equity fund		33,393	—	Daily	5 days
Equity long/short hedge funds		68,729	—	Monthly/ quarterly	30-90 days
Opportunistic fixed income hedge funds		89,314	—	Quarterly	45-90 days
Fund of hedge funds		1,743	—	Quarterly	90 days
Private equity funds		27,004	31,935	10 years	NA
Emerging market debt fund		58,187	—	Daily	Same day
Total	$	419,193	31,935		

Global bond fund includes fixed- and floating-rate debt securities of governments and government-related entities, as well as derivatives. The net asset value of the fund has been estimated using the net asset value per share of the investment. The fund provides full disclosure of the underlying holdings.

Global equity fund is an investment in a fund that invests in global equities. The net asset value of the fund has been estimated using the net asset value per share of the investment. The fund provides full disclosure of the underlying holdings.

(Continued)

Emerging markets equity fund is an investment in a fund that invests in emerging market equities. The net asset value of the fund has been estimated using the net asset value per share of the investment. The fund provides full disclosure of the underlying holdings.

Emerging market debt fund is an investment in a fund that invests in emerging market debt. The net asset value of the fund has been estimated using the net asset value per share of the investment. The fund provides full disclosure of the underlying holdings.

Equity long/short-hedge funds include investments in hedge funds that invest both long and short in United States and global common stocks through a hedge funds structure. The value of the investments in this category has been estimated using the net asset value per share of the investments.

Fund of hedge funds include investments in fund of hedge funds that pursue multiple strategies to diversify risks and reduce volatility. The value of the investments in this category has been estimated using the net asset value per share of the investments. The fund of hedge funds were liquidated over the course of 2013 with the exception of one fund of hedge funds investment, which as of December 31, 2014 has a value of $1,729, and one of the hedge fund of funds audit holdback is also included in this category. The fund is currently in liquidation and is making quarterly redemptions to shareholders. Since June 30, 2009, over 99% of the funds have been distributed.

Opportunistic fixed income hedge funds include investments in strategic fixed income and distressed debt hedge fund managers. These managers have the ability to invest across the capital structure and around the globe. The value of the investments in this category has been estimated using the net asset value per share of the investment.

Private equity funds include a limited partnership investment that focuses on health care services and information technology companies as well as a limited partnership that invests in distressed and opportunistic real estate investments. The fair value of the portfolio companies is determined using valuation techniques and procedures in accordance with recommendations by the American Institute of Certified Public Accountants (AICPA) for valuing private companies.

(Continued)

(Dollars in thousands)

The System's deferred compensation investments recorded as other assets that are measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2014 as follows:

		Fair value measurements using		
	Total	**Level 1**	**Level 2**	**Level 3**
Assets:				
Mutual funds:				
Large cap domestic equity	$ 43,443	43,443	—	—
Mid cap domestic equity	8,020	8,020	—	—
Small cap domestic equity	7,374	7,374	—	—
International equity	19,020	19,020	—	—
Fixed income	26,985	26,985	—	—
Balanced	8,978	8,978	—	—
Life cycle	2,692	2,692	—	—
Money market	3,213	3,213	—	—
Other	3,501	3,501	—	—
Total mutual funds	123,226	123,226	—	—
Guaranteed investment contracts	13,082	—	—	13,082
Total assets	$ 136,308	123,226	—	13,082

(Continued)

(Dollars in thousands)

		Fair value measurements, Level 3
Balance, December 31, 2013	$	11,411
Total interest income		236
Purchases		(4,742)
Sales		6,177
Balance, December 31, 2014	$	13,082

The System's deferred compensation investments recorded as other assets that are measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2013 as follows:

		Total	Fair value measurements using Level 1	Level 2	Level 3
Assets:					
Mutual funds:					
Large cap domestic equity	$	35,981	35,981	—	—
Mid cap domestic equity		8,034	8,034	—	—
Small cap domestic equity		7,326	7,326	—	—
International equity		17,640	17,640	—	—
Fixed income		25,473	25,473	—	—
Balanced		7,826	7,826	—	—
Life cycle		1,313	1,313	—	—
Money market		2,653	2,653	—	—
Other		2,769	2,769	—	—
Total mutual funds		109,015	109,015	—	—
Guaranteed investment contracts		11,411	—	—	11,411
Total assets	$	120,426	109,015	—	11,411

		Fair value measurements, Level 3
Balance, December 31, 2012	$	10,248
Total interest income		232
Purchases		3,619
Sales		(2,688)
Balance, December 31, 2013	$	11,411

(Continued)

(Dollars in thousands)

The System's deferred compensation investments recorded as other assets that are measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2012 as follows:

	Total	Fair value measurements using Level 1	Level 2	Level 3
Assets:				
Mutual funds:				
Large cap domestic equity	$ 29,010	29,010	—	—
Mid cap domestic equity	6,342	6,342	—	—
Small cap domestic equity	5,716	5,716	—	—
International equity	13,751	13,751	—	—
Fixed income	22,145	22,145	—	—
Balanced	6,094	6,094	—	—
Life cycle	976	976	—	—
Money market	2,603	2,603	—	—
Other	1,805	1,805	—	—
Total mutual funds	88,442	88,442	—	—
Guaranteed investment contracts	10,248	—	—	10,248
Total assets	$ 98,690	88,442	—	10,248

	Fair value measurements, Level 3
Balance, December 31, 2011	$ 10,026
Total realized and unrealized losses	219
Purchases	3,424
Sales	(3,421)
Balance, December 31, 2012	$ 10,248

(15) Benefit Plans

Defined–Benefit Cash Balance Plan

On December 31, 2008, the System froze a defined–benefit cash-balance pension plan (the Plan), covering a large number of noncontract employees. In 2013, the System received approval from the Internal Revenue Service to fully terminate the Plan effective as of December 31, 2012. In November 2013, the System fully distributed the plan assets to participants.

(Continued)

(Dollars in thousands)

The actual asset allocation as of December 31, 2012 was as follows:

	2012
Global equity	2%
Fixed income (debt securities)	82
Diversified funds of hedge funds	—
Real assets	2
Cash	14
	100%

The following table summarizes certain information for the Plan:

		2013	2012
Projected benefit obligation at beginning of year	$	498,821	444,834
Service cost – benefits earned during the year		—	442
Interest cost on the accumulated benefit obligation		11,826	20,078
Actuarial loss		3,043	58,844
Benefits paid from plan assets		(513,690)	(25,377)
Projected benefit obligation at end of year		—	498,821
Change in plan assets:			
Fair value of plan assets at beginning of year		460,925	430,233
Actual return on plan assets		765	10,070
Contributions from the System		52,000	46,000
Benefits paid from plan assets		(513,690)	(25,378)
Fair value of plan assets at end of year		—	460,925
Deficit		—	(37,896)
Net amount recognized	$	—	(37,896)
Accumulated benefit obligation at end of year	$	—	498,200

The projected benefit obligation (PBO) at December 31, 2012 was the present value of the future benefit payments accrued to date and included expected future salary increases. The PBO present value was determined by using a discount rate that was developed using a yield curve composed of hypothetical zero-coupon bond rates.

As of December 31, 2012, the net amount recognized of $37,896 is reported in the consolidated balance sheets as a noncurrent other liability.

(Dollars in thousands)

The Plan assets measured at fair value on a recurring basis were recorded using the fair value hierarchy at December 31, 2012 as follows:

	Total	Fair value measurements using Level 1	Level 2	Level 3
Investments:				
Money market collective fund	$ 65,842	65,842	—	—
Equity:				
International equity mutual funds	9,600	9,600	—	—
Total equity	9,600	9,600	—	—
Fixed income:				
U.S. agency securities	213,429	103,313	110,116	—
Corporate bonds	41,524	—	41,524	—
Mortgage, commercial, and asset-backed securities	22,872	—	22,872	—
Term loan/private placements	8,174	—	8,174	—
Sovereigns	23,140	22,124	1,016	—
Other	3,058	—	2,448	610
Total fixed income	312,197	125,437	186,150	610
Investments accounted for at net asset value:				
TIPS fund	4,950	—	4,950	—
Corporate bonds	61,621	—	61,621	—
Funds of hedge funds	1,682	—	—	1,682
Commodities	5,033	—	5,033	—
Total investments accounted for at net asset value	73,286	—	71,604	1,682
Total investments	$ 460,925	200,879	257,754	2,292

	Fair value measurements, Level 3 Total	Other-GIC	Hedge funds
Balance, December 31, 2011	$ 3,410	589	2,821
Total realized and unrealized losses included in excess of revenues over expenses	(16)	21	(37)
Purchases	—	—	—
Sales	(1,102)	—	(1,102)
Balance, December 31, 2012	$ 2,292	610	1,682

(Continued)

(Dollars in thousands)

The above information was determined using a measurement date of December 31 and the following assumptions:

	2012
Weighted average discount rate	3.00%
Rate of increase in future compensation levels	4.50

Net periodic pension cost consists of the following components:

	2013	2012
Service cost – benefits earned during the year	$ —	442
Interest cost on the accumulated benefit obligation	11,826	20,078
Expected return on plan assets	(11,090)	(13,018)
Net periodic pension cost	736	7,502
Mark-to-market adjustment	14,133	61,792
Total pension expense	$ 14,869	69,294

The net periodic pension cost was determined using the following assumptions:

	2012
Weighted average discount rate	4.70%
Weighted average expected return on plan assets	3.00
Rate of increase in future compensation levels	4.50

The System is making contributions pursuant to provisions of a collective bargaining agreement. The assets for these active participants were spun out of the Plan on January 2, 2013 and into a newly created stand-alone defined-benefit pension plan, known as the Allina Health Pension Plan for Collectively Bargained Employees (the new plan). This plan holds assets of $9,272 and $8,927; and has a projected benefit obligation of $9,754 and $8,806 using a discount rate of 3.54% and 4.29% as of December 31, 2014 and 2013, respectively. The System made contributions of $615 and $416 and recorded a total pension (expense) gain of ($1,218) and $449 in 2014 and 2013, respectively. The (unfunded) funded balance of ($482) and $121, respectively, as of December 31, 2014 and 2013 is reported in the consolidated balance sheet as a noncurrent other asset.

The defined-benefit pension plan of Courage Center was assumed in June 2013 with the acquisition of Courage Center. This plan, which was frozen in 2009, holds assets of $24,973 and $23,621 and has a projected benefit obligation of $34,282 and $26,585 using a discount rate of 4.0% and 5.0% as of

(Dollars in thousands)

December 31, 2014 and 2013, respectively. The System made contributions of $732 and $500 in 2014 and 2013, respectively, and recorded a total pension (expense) gain of ($7,077) and $3,601 in 2014 and 2013, respectively. The unfunded balance of $9,309 and $2,964 as of December 31, 2014 and 2013, respectively, is reported in the consolidated balance sheet as a noncurrent other liability.

Multi-employer Plans

Contributions to the union-sponsored multi-employer plans are made in accordance with collective bargaining agreements. The risks of participation in these multi-employer plans are different from single-employer plans in the following aspects: a) assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of other participating employers; b) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers; and c) if the System chooses to stop participating in some of its multi-employer plans and if the plan is underfunded, the System may be required to pay those plans an amount based on the underfunded status of the plan, referred to as the withdrawal liability. The System's participation in these plans for the year ended December 31, 2014 is outlined in the table below. The "EIN/Pension Plan Number" column provides the Employee Identification Number (EIN) and the three-digit plan number, if applicable. Unless otherwise noted, the most recent Pension Protection Act (PPA) zone status available in 2014, 2013, and 2012 is for the plan's year-end at December 31, 2013, 2012, and 2011, respectively. The zone status is based on information that the System received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are less than 80% funded, and plans in the green zone are at least 80% funded. The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The last column lists the expiration date(s) of the collective-bargaining agreement(s) to which the plans are subject:

Pension fund	EIN/Pension plan number	Pension protection act zone status 2013	2012	2011	FIP/RP Status pending/ implemented	Contributions of the System in plan year 2013	2012	2011
Twin City Hospitals Minnesota Nurses Association Pension Plan	41-6184922-001	Yellow	Yellow	Yellow	Implemented	$ 35,433	31,651	24,331
Other funds						4,247	3,945	3,655
Total contributions						$ 39,680	35,596	27,986

Total amounts expensed under the union-sponsored multi-employer plans were $41,827, $40,591, and $36,029 for 2014, 2013, and 2012, respectively.

The System contributes more than 5% of the total contributions to all of the plans in which it participated for the plan years 2013, 2012, and 2011. The System is required to make minimum contributions each year and will make contributions of $34,864 in 2015.

(Continued)

The funding improvement plan for the Twin City Hospitals Minnesota Nurses Association Pension Plan requires no contribution or benefit changes from the currently bargained amounts to achieve the funding improvement plan goals.

At the date the System's consolidated financial statements were issued, Forms 5500 were not available for the plan year ended in 2014.

Defined–Contribution Plans

Certain employees of the System are eligible to participate in defined–contribution plans, whereby 50% of the employees' initial 4% of salary contributions is matched. The defined–contribution plans were enhanced effective January 1, 2009 to provide an additional annual nonelective employer contribution for eligible employees as a replacement to the contribution made to the frozen pension plan. The additional contribution is given as a percent of pay, ranging from 3.0% to 4.5%, based on years of vesting service. Contributions are made during the year following the calendar year-end. The contribution payable to employees is recorded in other current liabilities. Total amounts expensed under defined–contribution plans were $59,467, $54,508, and $52,594 for 2014, 2013, and 2012, respectively.

Postretirement Welfare Benefits

The System provides postretirement welfare benefits to certain employees. Postretirement welfare cost was $481, $2,313, and $2,234 for 2014, 2013, and 2012, respectively. As of December 31, 2014, 2013, and 2012, accumulated postretirement benefit obligation was $11,094, $9,632, and $21,631, respectively, and accrued postretirement benefit cost was $10,800, $9,362, and $21,361, respectively. A discount rate of 3.65%, a rate of return on plan assets of 5.0%, and a medical plan trend rate of 7.0% in 2014, decreasing to 5.0% in 2020 and thereafter, have been assumed.

(16) Self-Insurance Reserves

The System insures its general and professional liability exposures under claims-made policies. Under these policies, the System has self-insured deductible amounts. Claim payments required in excess of certain occurrence and annual aggregate amounts are covered under umbrella policies. An insurance trust has been established, which covers specific claims periods. Actuarially determined amounts are contributed to pay for the estimated cost of claims. The System also self-insures workers' compensation exposures. If claims-made policies presently in force are not renewed or replaced with equivalent insurance, claims asserted after the end of the policy term will be uninsured.

The System has a fixed-rate surety bond in the amount of $49,943 at December 31, 2014 and $45,314 at December 31, 2013 and 2012. The surety bond was obtained in connection with the System's self-insured workers' compensation program at a rate of 0.31% per annum.

The System also has unused letters of credit totaling $2,536 through June 30, 2015. The letters of credit were obtained in connection with the System's self-insured automobile and construction programs at a fee of 0.45% per annum.

(Continued)

The System has made provisions for estimated professional and general liability and workers' compensation claims that have been retained by the System because of deductible provisions of various policies or because of unasserted claims and other uninsured exposures. Reserves of $98,768, $111,022, and $116,250 as of December 31, 2014, 2013, and 2012, respectively, have been recorded based on undiscounted historical data for professional and general liability and on a present-value basis using an annual discount rate of 2% for workers' compensation claims.

Under the comprehensive welfare benefit plan, the System has made provisions for claims reported but not paid and claims incurred but not reported of $16,498, $14,094, and $17,218 as of December 31, 2014, 2013, and 2012, respectively. Management of the plan believes the provisions are adequate to cover claims incurred.

(17) Taxes

The System has been determined to qualify as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. The System has also been determined to be exempt from federal and state income tax on related income under Section 501(a) of the Internal Revenue Code and Minnesota Statute Section 290.05, Subdivision 2. Certain of the System's subsidiaries and affiliates qualify as tax-exempt organizations, while others are taxable. The System and its subsidiaries paid taxes of $1,717, $1,944, and $942 in 2014, 2013, and 2012, respectively.

As of December 31, 2014, 2013, and 2012, the taxable subsidiaries of the System's continuing operations had a gross deferred tax asset of $68,851, $79,644, and $78,049, respectively, resulting from net operating loss carryforwards, employee compensation and benefits accruals, provision for bad debts, and limitation of charitable contributions, offset by valuation allowances of $68,569, $78,946, and $77,137, respectively, and a gross deferred tax liability of $282, $697, and $912, respectively, primarily attributable to depreciation and a change in accounting method of a taxable subsidiary. The valuation allowance decreased by $10,377 and increased by $1,809 and $1,391 during 2014, 2013, and 2012, respectively.

As of December 31, 2014, the continuing operations of the System and its subsidiaries had net operating loss carryforwards of $119,453, for income tax purposes, which expire in various years through 2034.

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement and tax return methods of accounting. Deferred tax assets and liabilities are measured using the enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled.

The System has analyzed income tax positions taken for filing with the Internal Revenue Service and all state jurisdictions where it operates. The System believes that income tax filing positions will be sustained upon examination and does not anticipate any adjustments that would result in a material adverse effect on the System's consolidated financial statements. As of December 31, 2014, 2013, and 2012, the System does not have any significant liabilities for uncertain tax benefits.

(Continued)

(Dollars in thousands)

(18) Commitments and Contingencies

The System has various noncancelable operating occupancy lease agreements and other operating lease agreements for computer, medical, communication, and other equipment. The terms of certain of the lease agreements contain lease escalation clauses, allow for renewal of the leases, and require the System to pay operating costs in addition to minimum base rent. Base rent expense for operating leases totaled $27,581, $27,584, and $23,011 for the years ended December 31, 2014, 2013, and 2012, respectively.

Aggregate future minimum lease payments required under operating lease agreements in effect on December 31, 2014 are as follows:

2015	$	27,833
2016		26,681
2017		24,382
2018		22,614
2019		19,332
Thereafter		84,328
	$	205,170

The System has incurred financing obligations relating to space lease agreements in a medical office building and a clinic. Under the guidance in ASC Topic 840, *Leases*, the System is considered the owner of the buildings. As of December 31, 2014, 2013, and 2012, the cost of the buildings and the related financing obligation are included in the accompanying consolidated balance sheets in property and equipment, net, and in other liabilities, respectively.

Future payments related to the financing transactions, which will be recorded as interest expense, are as follows:

2015	$	1,188
2016		1,202
2017		745
2018		716
2019		668

Approximately 41% of employees are represented by various collective bargaining arrangements, of whom approximately 36% are represented by arrangements that are pending or expire within one year.

Laws and regulations governing the Medicare program are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The System believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on its consolidated financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare program.

(Dollars in thousands)

The System is subject to various legal proceedings and claims that are incidental to its normal business activities. With respect to these actions, established reserves are fairly stated, though actual results could vary from the estimates and assumptions that were used.

(19) Acquisitions

On June 1, 2013, the System acquired and became the sole owner of Courage Center and the Courage Foundation to create a unique model of care that will make a difference in the communities the System serves. Courage Center provides rehabilitation services and was integrated with an existing service line of the System. The Courage Foundation also was integrated into an existing foundation of the System. The results of Courage Center's operations, including total revenues of $16,809, have been included in the consolidated financial statements since the acquisition date.

On September 1, 2013, the System acquired and became the sole owner of Regina Medical Center and the Regina Foundation. Through the acquisition, the System will increase the healthcare services provided in the Regina Medical Center service area. Prior to becoming the sole owner of Regina Medical Center, the System had been a 25% member. Regina Medical Center is a hospital located outside the metropolitan area. The results of Regina Medical Center's operations, including total revenues of $18,186, have been included in the consolidated financial statements since the acquisition date.

There was no consideration transferred for the acquisitions, resulting in the System recording an inherent contribution received for the net assets acquired. The following table summarizes the recognized amounts of estimated fair value of the assets acquired and liabilities assumed at the respective acquisition dates.

		Total	Courage Center and Courage Foundation	Regina Medical Center and Regina Foundation
Current and other long-term assets	$	103,677	68,367	35,310
Property and equipment		67,334	28,411	38,923
Liabilities		(34,675)	(28,148)	(6,527)
Long-term debt		(31,475)	—	(31,475)
Previously held equity interest		(6,525)	—	(6,525)
Total identifiable net assets acquired	$	98,336	68,630	29,706
Unrestricted nonoperating contribution received in acquisition	$	76,611	49,503	27,108
Restricted contribution received in acquisition		21,725	19,127	2,598
Total contribution received in acquisition	$	98,336	68,630	29,706

(Continued)

(Dollars in thousands)

(20) Functional Expenses

The System provides health care services to residents within its geographic location. Expenses related to providing these services included in the consolidated statements of operations and changes in net assets are as follows:

	2014	2013	2012
Healthcare services	$ 2,906,919	2,781,237	2,652,270
General and administrative	550,818	505,889	498,069
	$ 3,457,737	3,287,126	3,150,339

(21) Subsequent Events

On January 1, 2015, Rice County District One Hospital transferred substantially all assets and liabilities of the Rice County District One Hospital to the System. The transfer resulted in the System recognizing an unrestricted nonoperating contribution received in acquisition of $36,718.

The System has evaluated subsequent events from the consolidated balance sheet date through March 10, 2015, the date at which the consolidated financial statements were issued, and determined there are no other items to disclose.

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APPENDIX C

DEFINITIONS OF CERTAIN TERMS AND SUMMARIES OF PRINCIPAL DOCUMENTS

DEFINITIONS OF CERTAIN TERMS UNDER THE MASTER INDENTURE AND SECURITY AGREEMENT

"Accelerable Instrument" means any Obligation or any mortgage, indenture, loan agreement or other instrument under which there has been issued or incurred, or by which there is secured, any Indebtedness evidenced by an Obligation, which Obligation or instrument provides that, upon the occurrence of an event of default under such Obligation or instrument, the holder thereof may request that the Master Trustee declare such Obligation or Indebtedness due and payable prior to the date on which it would otherwise become due and payable.

"Accreted Value" means, when used with respect to Discount Obligation(s) or Discounted Related Bonds and as of any particular date, the "accreted value" of such Discount Obligation(s) as of such date as set forth in a table in the Related Supplemental Indenture or the "accreted value" of such Discount Related Bonds as of such date as set forth in a table in the Related Bond Indenture; provided that if no such table is included in the Related Supplemental Indenture or in the Related Bond Indenture, the "Accreted Value" shall at all times be equal to the principal amount of such Obligations or Bonds.

"Balloon Indebtedness" means Funded Indebtedness, 25% or more of the original principal amount of which matures during any consecutive twelve month period, if such maturing principal amount is not required to be amortized below such percentage by mandatory redemption or prepayment prior to such twelve month period. Balloon Indebtedness does not include Funded Indebtedness that otherwise would be classified under the Master Indenture as Put Indebtedness.*

"Board Resolution" means a copy of a resolution delivered to the Master Trustee and certified by the Secretary or an Assistant Secretary of a Person to have been duly adopted by the Governing Body of such Person and to be in full force and effect on the date of such delivery.

"Bond Indenture" means the Bond Indenture dated as of September 1, 2015 between the Corporation and the Bond Trustee related to the Bonds, as the same may be amended or supplemented from time to time in accordance with the provisions thereof.

"Bond Trustee" means Wells Fargo Bank, National Association, Minneapolis, Minnesota, as trustee under the Bond Indenture or any successor trustee under the Bond Indenture.

"Bondholder," "Holder," "holder" or *"owner of the Bonds"* means for purposes of the Master Indenture the registered owner of any Related Bond.

"Bonds" or *"Series 2015 Bonds"* means the Allina Health System Taxable Bonds, Series 2015 to be issued under the Bond Indenture.

"Book Value," when used with respect to Property, means the value of such Property, net of accumulated depreciation and amortization, as reflected in the most recent financial statements of the Credit Group or any Member thereof, provided that such aggregate shall be calculated in such a manner that no portion of the value of any Property of any Credit Group Member is included more than once.

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* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

"Capitalized Lease" means any lease of real or personal property which, in accordance with generally accepted accounting principles, is required to be capitalized on the balance sheet of the lessee.

"Capitalized Rentals" means, as of the date of determination, the aggregate Net Rentals due and to become due under a Capitalized Lease under which a Person is a lessee.

"Code" means the Internal Revenue Code of 1986, as amended from time to time. Each reference to a section of the Code herein shall be deemed to include the United States Treasury Regulations, including temporary and proposed regulations, relating to such section which are applicable to a series of Related Bonds or the use of the proceeds thereof.

"Consultant" means a professional consulting, financial advisory, accounting, investment banking or commercial banking firm selected by the Obligated Group Agent, having the skill and experience necessary to render the particular report required and having a favorable reputation for such skill and experience, which firm does not control any Credit Group Member and is not controlled by or under common control with any Credit Group Member.

"Corporation" means Allina Health System, a Minnesota nonprofit corporation, and its successors and assigns and any surviving, resulting or transferee corporation.

"Counsel" means an attorney duly admitted to practice law before the highest court of any state and, without limitation, may include independent or in-house legal counsel for any Credit Group Member, the Master Trustee or a Related Bond Trustee.

"Credit Group" means, collectively, all the Credit Group Members.

"Credit Group Member" means (a) each Obligated Group Member, (b) each Limited Credit Group Participant, (c) each Unlimited Credit Group Participant, (d) each Designated Affiliate, or (e) each Limited Designated Affiliate.

"Days Cash on Hand" means for the period tested, the aggregate amount of unrestricted and unencumbered (i) cash, (ii) cash equivalents and/or (iii) Board designated marketable debt and equity securities divided by the quotient of (x) operating expenses less depreciation and amortization and expenses allocable to self-insurance reserves divided by (y) the number of calendar days in the period. Notwithstanding any of the foregoing to the contrary, Days Cash on Hand shall not include (A) self-insurance funds, (B) proceeds of any short-term borrowings including, without limitation, internal affiliate loans and draws on lines of credit regardless of the maturity date of the line of credit, (C) amounts received from accounts receivable financings or factoring, (D) proceeds of put debt not supported by a liquidity facility with term-out features, (E) funds or investments subject to any restrictions, permanent or temporary, regardless of whether such funds or investments are considered restricted for purposes of generally accepted accounting principles or (F) any collateral required under an Interest Rate Agreement that has been posted. For purposes of determining Days Cash on Hand, unrestricted and unencumbered cash includes any amounts in hedge funds.*

"Debt Service Requirements" means, with respect to the period of time for which calculated, the aggregate of the payments required to be made during such period in respect of principal (whether at maturity, as a result of mandatory sinking fund redemption, mandatory prepayment or otherwise) and interest on outstanding Funded Indebtedness of each Person or a group of Persons with respect to which calculated; provided that: (a) interest shall be excluded from the determination of the Debt Service Requirements to the extent that Funded Interest is used to pay such interest when due and payable; (b) principal of Indebtedness shall be excluded from the determination of Debt Service Requirements to the extent that amounts on deposit in an irrevocable escrow and such amounts (including, where appropriate, the earnings or other increment to accrue thereon) are applied to pay such principal; (c) principal of Funded Indebtedness shall be excluded to the extent such principal is paid with the proceeds of other Funded Indebtedness when due and payable or proceeds of remarketing to be used for payment of such principal;

* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

(d) principal and interest of Funded Indebtedness shall be excluded to the extent such principal and interest is paid by a Limited Credit Group Participant and such Funded Indebtedness is not secured by an Obligation; and (e) principal and interest of Funded Indebtedness during a particular period shall be excluded to the extent that the Guaranty which created the obligation to pay such principal and interest does not require the Person acting as guarantor to pay such principal or interest during such period because conditions precedent such as, but not limited to, a demand for payment from such Person or default by the Primary Obligor have not been met.

"Designated Affiliate" means a Person designated by the Obligated Group Agent as such in accordance with Section 401 of the Master Indenture, and over which any Obligated Group Member maintains control, directly or indirectly, including the power to direct the management, policies, disposition of assets and actions of such Designated Affiliate to the extent required to cause such Designated Affiliate to comply with the terms and conditions of the Master Indenture, whether through the ownership of such Person's voting securities, partnership interests, membership, reserved powers, the power to appoint such Person's members, trustees or directors or otherwise.

"Discount" means, with respect to Discount Obligations or Discount Related Bonds, the difference between the original principal amount of such Discount Obligations or Discount Related Bonds and the price (not including accrued interest) at which such Bonds are initially offered or reoffered and sold to the public or the initial purchasers thereof other than the underwriters thereof.

"Discount Obligations" or *"Discount Related Bonds"* means (i) in the case of Obligations, any Obligation issued to secure Discount Related Bonds or initially offered to the public at a price less than the principal amount thereof, and (ii) in the case of Discount Related Bonds, any Related Bonds initially offered (other than to the underwriters thereof) at a price less than the principal amount thereof.

"Escrow Obligations" means, (i) with respect to any Obligation which secures a series of Related Bonds, the obligations permitted to be used to defease, refund or advance refund such series of Related Bonds under the Related Bond Indenture, or (ii) with respect to any other Obligation, those securities identified as such in the Supplemental Master Indenture pursuant to which such Obligation was issued.

"Existing Bonds" means any revenue bonds or similar obligations issued by any state, commonwealth or territory of the United States or any municipal corporation or other political subdivision formed under the laws thereof or any constituted authority, agency or instrumentality of any of the foregoing empowered to issue obligations on behalf thereof, the proceeds of which were loaned or otherwise made available to the Corporation or one of its predecessor corporations in consideration, whether in whole or in part, of the execution, authentication and delivery of a Master Note or Notes issued pursuant to the terms of the 1985 Master Indenture to such governmental issuer.

"Expenses" means, for any period, the aggregate of all expenses calculated under generally accepted accounting principles, including without limitation any taxes, incurred by the Person or group of Persons involved during such period, but excluding (a) interest on Funded Indebtedness, (b) depreciation and amortization, (c) any unrealized loss resulting from changes in the value of investment securities, including any Interest Rate Agreement, (d) extraordinary expenses or nonrecurring expenses (including without limitation losses on the sale of assets other than in the ordinary course of business and losses on the extinguishment of debt), (e) any expenses resulting from a forgiveness of or the establishment of reserves against Indebtedness of an affiliate which does not constitute an extraordinary expense, (f) losses resulting from any reappraisal, revaluation or write-down of fixed or capital assets, and (g) if such calculation is being made with respect to the Credit Group, excluding any such expenses attributable to transactions between any Credit Group Member and any other Credit Group Member.

"Facilities" means all land, leasehold interests and buildings and all fixtures and equipment (as defined in the Uniform Commercial Code or equivalent statute in effect in the state where such fixtures or equipment are located) of a Person.

"Fiscal Year" means, for the Obligated Group Agent, any 12-month period beginning on January 1 of any calendar year and ending on December 31 of such calendar year or such other consecutive 12-month period selected by the Obligated Group Agent as its fiscal year; and for any other Credit Group Member, any consecutive 12-month

period selected by such Member and not unacceptable to the Obligated Group Agent as the fiscal year for such Member.

"Funded Indebtedness" means, with respect to any Person, (a) all Indebtedness of such Person for money borrowed or credit extended which is not Short-Term; (b) all Indebtedness of such Person incurred or assumed in connection with the acquisition or construction of Property which is not Short-Term; (c) the Person's Guaranties of Indebtedness which are not Short-Term; and (d) Capitalized Rentals under Capitalized Leases entered into by the Person; provided, however, that Indebtedness that could be described by more than one of the foregoing categories shall not in any case be considered more than once for the purpose of any calculation made pursuant to the Master Indenture.

"Funded Interest" means amounts irrevocably deposited in escrow to pay interest on Funded Indebtedness or on Related Bonds and interest earned on amounts irrevocably deposited in escrow to the extent such interest earned is applied to pay interest on Funded Indebtedness or on Related Bonds, including capitalized interest held in escrow to pay interest during a construction period.

"Governing Body" means the board of directors, board of trustees or similar group in which the right to exercise the powers of corporate directors or trustees is vested or an executive committee of such board or any duly authorized committee of that board to which the relevant powers of that board have been lawfully delegated.

"Guaranty" means all obligations of a Person guaranteeing, or in effect guaranteeing, any Indebtedness or other obligation of any Primary Obligor in any manner, whether directly or indirectly including but not limited to obligations incurred through an agreement, contingent or otherwise, by such Person: (1) to purchase such Indebtedness or obligation or any Property constituting security therefor; (2) to advance or supply funds: (i) for the purchase or payment of such Indebtedness or obligation, or (ii) to maintain working capital or other balance sheet condition; (3) to purchase securities or other Property or services primarily for the purpose of assuring the owner of such Indebtedness or obligation of the ability of the Primary Obligor to make payment of the Indebtedness or obligation; or (4) otherwise to assure the owner of such Indebtedness or obligation against loss in respect thereof.

"Historical Debt Service Coverage Ratio" means, for any period of time, the ratio consisting of a numerator equal to the amount determined by dividing Income Available for Debt Service for that period by the Debt Service Requirements on Funded Indebtedness for such period and a denominator of one; provided that, when such calculation is being made with respect to the Credit Group, Income Available for Debt Service and Debt Service Requirements shall be determined only with respect to those Persons who are Credit Group Members at the close of such period.

"Income Available for Debt Service" means for any period, the sum of (a) the excess (or deficit) of Revenues over Expenses of the Obligated Group Members, the Designated Affiliates and the Unlimited Credit Group Participants for such period, plus (b) for each Limited Credit Group Participant, the amount actually received by an Obligated Group Member or Designated Affiliate during such period pursuant to the contract or agreement between such Limited Credit Group Participant and the Obligated Group Member or Designated Affiliate, plus (c) for each Limited Designated Affiliate, the lesser of (1) the amount which is the excess (or deficit) of Revenue over Expenses or (II) the amount permitted to be transferred by the limitations imposed by statute, regulation or judicial or administrative order or pursuant to a contract with the State or any governmental agency having jurisdiction over the Limited Designated Affiliate.

"Indebtedness" means, for any Person, (a) all Guaranties by such Person, (b) all liabilities (exclusive of reserves such as those established for deferred taxes or litigation) recorded or required to be recorded as such on the audited financial statements of such Person in accordance with generally accepted accounting principles, and (c) all obligations for the payment of money incurred or assumed by such Person (i) due and payable in all events or (ii) if incurred or assumed primarily to assure the repayment of money borrowed or credit extended, due and payable upon the occurrence of a condition precedent or upon the performance of work, possession of Property as lessee, rendering of services by others or otherwise and shall include, without limitation, Non-Recourse Indebtedness; provided that Indebtedness shall not include Indebtedness of one Credit Group Member to another Credit Group Member, any Guaranty by any Credit Group Member of Indebtedness of any other Credit Group Member, the joint and several liability of any Credit Group Member on Indebtedness issued by another Credit Group Member, Interest

Rate Agreements or any obligation to repay moneys deposited by patients or others with a Credit Group Member as security for or as prepayment of the cost of patient care or any rights of residents of life care, elderly housing or similar facilities to endowment or similar funds deposited by or on behalf of such residents or accounts payable, trade accounts or accrued expenses or liabilities or similar obligations incurred or assumed by a Person in the ordinary course of business.

"Interest Rate Agreement" means an interest rate exchange, hedge or similar agreement, which agreement may include, without limitation, an interest rate swap, a forward or futures contract or an option (e.g. a call, put, cap, floor or collar) and which agreement does not constitute an obligation to repay money borrowed, credit extended or the equivalent thereof.

"Issue Date" means September 16, 2015.

"Lien" means any mortgage, pledge or lease of, security interest in or lien, charge, restriction or encumbrance on any Property of the Person involved in favor of, or which secures any obligation to, any Person other than a Credit Group Member and any Capitalized Lease under which any Credit Group Member is lessee and the lessor is not a Credit Group Member.

"Limited Credit Group Participant" means a Person identified by the Obligated Group Agent to the Master Trustee with whom an Obligated Group Member, a Designated Affiliate or a Limited Designated Affiliate has entered into a contract or other agreement, under which such Person is obligated to make such portion of the payments required by the Master Indenture in the amount specified in such contract or other agreement, perform all of the other obligations of a Credit Group Member under the Master Indenture, and do all things necessary to permit the Obligated Group to perform its obligations and covenants under the Master Indenture; provided that together with such identification there shall be delivered to the Master Trustee (a) a fully executed copy of such contract or other agreement and (b) an opinion of Counsel to the effect that such contract or other agreement is a valid and binding obligation of such Person enforceable in accordance with its terms, subject to customary exceptions for bankruptcy, insolvency and other laws generally affecting enforcement of creditors' rights and application of general principles of equity and to the exceptions set forth in Exhibit A to the Master Indenture.

"Limited Designated Affiliate" means a Person meeting the definition of a Designated Affiliate but is subject to limitations under statute, regulation or judicial or administrative order or pursuant to a contract with the State or any governmental agency having jurisdiction over the Limited Designated Affiliate as to the amount or frequency of transfer of assets to the Obligated Group Members. A Person may not be simultaneously a Limited Designated Affiliate and a Designated Affiliate for purposes of the Master Indenture.

"Master Indenture" or *"Master Trust Indenture"* means the Master Trust Indenture dated October 1, 1998, as it may from time to time be amended or supplemented in accordance with the terms thereof.

"Master Trustee" means Wells Fargo Bank, National Association or any successor trustee under the Master Indenture.

"Moody's" means Moody's Investors Service, Inc., a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, and, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Corporation by notice to the Master Trustee.

"Net Rentals" means all fixed rents (including as such all payments which the lessee is obligated to make to the lessor on termination of the lease or surrender of the Property other than upon termination of the lease for a default thereunder) payable under a lease or sublease of real or personal Property excluding any amounts required to be paid by the lessee (whether or not designated as rents or additional rents) on account of maintenance, repairs, insurance, taxes and similar charges. Net Rentals for any future period under any so-called "percentage lease" shall be computed on the basis of the amount reasonably estimated to be payable thereunder for such period, but in any event not less than the amount paid or payable thereunder during the immediately preceding period of the same

duration as such future period; provided that the amount estimated to be payable under any such percentage lease shall in all cases recognize any change in the applicable percentage called for by the terms of such lease.

"1985 Master Indenture" means the Master Trust Indenture between the Corporation, as successor to Health Central System and Norwest Bank Minnesota, National Association, as master trustee, dated as of October 1, 1985, as amended and supplemented from time to time.

"Non-Recourse Indebtedness" means any Indebtedness the liability for which is effectively limited to property, plant and equipment (as classified under generally accepted accounting principles) and the income therefrom, the cost of which Property, Plant and Equipment shall have been financed with the proceeds of such Indebtedness with no recourse, directly or indirectly, to any other Property of any Credit Group Member.

"Obligated Group" means, collectively, the Obligated Group Members.

"Obligated Group Agent" means the Corporation or such other Obligated Group Member as may be designated from time to time pursuant to written notice to the Master Trustee executed by an officer of the Governing Body of the Corporation or, if the Corporation is no longer an Obligated Group Member, of each Obligated Group Member.

"Obligated Group Member" means the Corporation and any Person who is listed on Exhibit C to the Master Indenture as a result of having fulfilled the requirements for entry into the Obligated Group as set forth in Section 302 of the Master Indenture and which has not, in either case, ceased such status pursuant to Section 303 of the Master Indenture.

"Obligation" means generally, any evidence of Indebtedness or Interest Rate Agreement issued by an Obligated Group Member pursuant to the Master Indenture which has been authenticated by the Master Trustee pursuant to Section 204 of the Master Indenture, or specifically, as applicable, the Series 2015 Obligation.

"Obligation Holder" means the registered owner of any fully registered or book entry Obligation unless alternative provision is made in the Supplemental Master Indenture pursuant to which such Obligation is issued for establishing ownership of such Obligation, in which case such alternative provision shall control.

"Officer's Certificate" means a certificate signed, in the case of a certificate delivered by a corporation, by the President or any Vice-President or any other officer authorized to sign by resolution of such corporation or, in the case of a certificate delivered by any other Person, the chief executive or chief financial officer of such other Person.

"Opinion of Bond Counsel" means a written opinion of nationally recognized municipal bond counsel.

"Outstanding Obligations" or *"Obligations outstanding"* means all Obligations which have been duly authenticated and delivered by the Master Trustee under the Master Indenture, except:

(a) Obligations canceled after purchase in the open market or because of payment at or prepayment or redemption prior to maturity;

(b) (i) Obligations for the payment, prepayment or redemption of which cash or Escrow Obligations shall have been theretofore deposited with the Master Trustee (whether upon or prior to the maturity, prepayment or redemption date of any such Obligations); provided that if such Obligations are to be prepaid or redeemed prior to the maturity thereof, notice of such prepayment or redemption shall have been given or irrevocable arrangements satisfactory to the Master Trustee shall have been made therefor, or waiver of such notice satisfactory in form to the Master Trustee shall have been filed with the Master Trustee and (ii) Obligations securing Related Bonds for the payment, prepayment or redemption of which cash or Escrow Obligations shall have been theretofore deposited with the Related Bond Trustee (whether upon or prior to the maturity, prepayment or redemption date of any such Obligations); provided that if such Related Bonds are to be prepaid or redeemed prior to the maturity thereof, notice of such prepayment

or redemption shall have been given or arrangements satisfactory to the Related Bond Trustee shall have been made therefor, or waiver of notice satisfactory in form to the Related Bond Trustee shall have been filed with the Related Bond Trustee;

(c) Obligations in lieu of which others have been authenticated under the Master Indenture; and

(d) For the purpose of all consents, approvals, waivers and notices required to be obtained or given under the Master Indenture, Obligations held or owned by any Credit Group Member.

Notwithstanding the foregoing, any Obligation securing Related Bonds shall be deemed outstanding if such Related Bonds are Outstanding.

"Outstanding Related Bonds" or *"Related Bonds outstanding"* means all Related Bonds which have been duly authenticated and delivered by the Related Bond Trustee under the Related Bond Indenture and are deemed outstanding under the terms of such Related Bond Indenture or, if such Related Bond Indenture does not specify when Related Bonds are deemed outstanding thereunder, all such Related Bonds which have been so authenticated and delivered, except:

(a) Related Bonds canceled after purchase in the open market or because of payment at or prepayment or redemption prior to maturity;

(b) Related Bonds for the payment or prepayment or redemption of which cash or Escrow Obligations of the type described in clause (i) of the definition thereof shall have been theretofore deposited with the Related Bond Trustee (whether upon or prior to the maturity, prepayment or redemption date of any such Bonds) in accordance with the Related Bond Indenture; provided that if such Bonds are to be redeemed prior to the maturity thereof, notice of such redemption shall have been given or arrangements satisfactory to the Related Bond Trustee shall have been made therefor, or waiver of such notice satisfactory in form to the Related Bond Trustee shall have been filed with the Related Bond Trustee;

(c) Related Bonds in lieu of which others have been authenticated under the Related Bond Indenture; and

(d) For the purposes of all covenants, approvals, waivers and notices required to be obtained or given under the Related Bond Indenture, Related Bonds held or owned by any Credit Group Member.

"Paying Agent" means the bank or banks, if any, designated pursuant to a Related Bond Indenture to receive and disburse the principal of and interest on any Related Bonds or designated pursuant to the Master Indenture to receive and disburse the principal of and interest on any Obligations.

"Permitted Encumbrances" means the Master Indenture, any Related Loan Document, any Related Bond Indenture and, as of any particular time:

(a) Liens arising by reason of good faith deposits by a Credit Group Member in connection with tenders, leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by any Credit Group Member to secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges; any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or governmental regulation for any purpose at any time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any Credit Group Member to maintain self-insurance or to participate in any funds established to cover any insurance risks or in connection with workmen's compensation, unemployment insurance, pensions or profit sharing plans or other social security plans or programs, or to share in the privileges or benefits required for corporations participating in such arrangements;

(b) any Lien on Property acquired subject to an existing Lien, if at the time of such acquisition, the aggregate amount remaining unpaid on the Indebtedness secured thereby (whether or not assumed by the Credit Group Member) does not exceed the fair market value or (if such Property has been purchased) the lesser of the acquisition price or the fair market value of the Property subject to such Lien as determined in good faith by the Governing Body of the Credit Group Member;

(c) any Lien on any Property of any Credit Group Member granted in favor of or securing Indebtedness to any other Credit Group Member;

(d) any Liens on Property if such Lien equally and ratably secures all of the Obligations, and, if the Obligated Group Agent shall so determine, any other Indebtedness of any Credit Group Member;

(e) leases which relate to Property of a Credit Group Member which is of a type that is customarily the subject of such leases, such as office space for physicians and educational institutions, including leases for food service facilities, gift shops and emergency room, radiology or other hospital-based specialty services, pharmacy and similar departments; leases, licenses or similar rights to use Property to which any Credit Group Member is a party existing as of October 1, 1998, and any renewals and extensions thereof,

(f) Liens for taxes and special assessments which are not then delinquent, or if then delinquent are being contested in accordance with Section 409 of the Master Indenture;

(g) any mechanic's, laborer's, materialman's, supplier's or vendor's Lien or right in respect thereof if payment is not yet due under the contract in question or if such Lien is being contested in accordance with the provisions of Section 409 of the Master Indenture;

(h) Liens on or in Property given, granted, bequeathed or devised by the owner thereof existing at the time of such gift, grant, bequest or devise, provided that (i) such Liens consist solely of restrictions on the use thereof or the income therefrom, or (ii) such Liens secure Indebtedness which is not assumed by any Credit Group Member and such Liens attach solely to the Property (including the income therefrom) which is the subject of such gift, grant, bequest or devise;

(i) Liens of or resulting from any judgment or award, the time for the appeal or petition for rehearing of which shall not have expired, or in respect of which any Credit Group Member shall at any time in good faith be prosecuting an appeal or proceeding for a review and in respect of which a stay of execution pending such appeal or proceeding for review shall be in existence;

(j) any security interest in a project fund, rebate fund, any depreciation reserve, debt service or interest reserve, debt service fund or any similar fund established pursuant to the terms of any Supplemental Master Indenture, Related Bond Indenture or Related Loan Document in favor of the Master Trustee, a Related Bond Trustee or the holder of the Indebtedness issued pursuant to such Supplemental Master Indenture, Related Bond Indenture or Related Loan Document or the provider of any liquidity or credit support for such Related Bonds or Indebtedness;

(k) any Lien on any Related Bond or any evidence of Indebtedness of any Credit Group Member acquired by or on behalf of any Credit Group Member by the provider of liquidity or credit support for such Related Bond or Indebtedness;

(l) Liens on accounts receivable arising as a result of the sale of such net accounts receivable without recourse, provided that the principal amount of Indebtedness secured by any such Lien does not exceed the aggregate sales price of such accounts receivable received by the Credit Group Member selling the same by more than 25%;

(m) Liens on any Property of a Credit Group Member at the effective date of the Master Indenture or existing at the time any Person becomes a Credit Group Member; provided that no such Lien

(or the amount of Indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of such Credit Group Member not subject to such Lien on such date unless such Lien as so increased, extended, renewed or modified is otherwise permitted under the Master Indenture;

(n) Liens on Property of a Person existing at the time such Person is merged into or consolidated with a Credit Group Member, or at the time of a sale, lease or other disposition of the properties of a Person as an entirety or substantially as an entirety to a Credit Group Member which becomes part of a Property that secures Indebtedness that is assumed by a Credit Group Member as a result of any such merger, consolidation or acquisition; provided, that no such Lien may be increased, extended, renewed or modified after such date to apply to any Property of a Credit Group Member not subject to such Lien on such date unless such Lien as so increased, extended, renewed or modified is otherwise permitted under the Master Indenture;

(o) Liens which secure Non-Recourse Indebtedness;

(p) Liens on any Property of a Credit Group Member to secure any Indebtedness incurred for the purpose of financing all or any part of the purchase price thereof or the cost of constructing or improving the Property which is theretofore unimproved real property subject to such Liens; and

(q) Liens on Property of a Credit Group Member, in addition to those Liens permitted as defined above in this definition of Permitted Encumbrances, if the total aggregate Book Value of the Property subject to a Lien of the type described in this subsection (q) plus Liens on accounts receivable sold with recourse does not exceed 35% of the Book Value of the total assets of the Credit Group Members; and

(r) Liens on Property permitted under the 1985 Master Trust Indenture and existing on the date of execution of the Master Trust Indenture.

"Permitted Investments" shall mean for purposes of the Master Indenture (i) with respect to any Obligation which secures a series of Related Bonds, the obligations in which the Related Bond Trustee may invest funds under the Related Bond Indenture, (ii) with respect to any Obligations for which a Supplemental Master Indenture specifies certain permitted investments, the investments so specified and (iii) in all other cases such legal and prudent investments as are reasonably agreed upon by the Obligated Group Agent and the Master Trustee.

"Person" means any natural person, firm, joint venture, association, partnership, business trust, corporation, limited liability corporation, public body, agency or political subdivision thereof or any other similar entity.

"Pledged Revenues" means all gross revenues, profits, receipts, benefits, royalties, money and income of any Credit Group Member arising from services provided by Credit Group Members or arising in any manner related to the Credit Group Members' operations, including, without limitation, (i) the Credit Group Members' rights under agreements with insurance companies, Medicare, Medicaid, governmental units and prepaid health organizations, including rights to Medicare and Medicaid loss recapture under applicable regulations and (ii) gifts, grants, bequests, donations, contributions and pledges to any Credit Group Member and (iii) business interruption insurance proceeds, and all rights to receive the foregoing, whether now owned or hereafter acquired by any Credit Group Member and regardless of whether generated in the form of accounts, accounts receivable, general intangibles, contract rights or chattel paper and all proceeds of the foregoing, whether cash or noncash; excluding, however, gifts, grants, bequests, donations, contributions and pledges to any Credit Group Member heretofore or hereafter made, and the income and gains derived therefrom, which are specifically restricted by the donor or grantor to a particular purpose which is inconsistent with their use for payments required under the Master Indenture or on the Obligations. "Pledged Revenues" shall not be deemed to include revenues from leases which relate to the Facilities of the Credit Group Members which are of a type that are customarily entered into for such Facilities, such as office space for physicians and educational institutions, food service facilities, gift shops, radiology and other hospital-based specialty services and pharmacy and similar departments.

"Primary Obligor" means the Person who is primarily obligated on an obligation which is guaranteed by another Person.

"Project" means eligible corporate purposes of the Corporation, as further described in the Bond Indenture.

"Property" means any and all rights, titles and interests in and to any and all property, whether real or personal, tangible (including cash) or intangible, wherever situated and whether now owned or hereafter acquired.

"*Put Indebtedness*" means Indebtedness that is payable or required to be purchased or redeemed, at the option of the holder thereof, prior to its stated maturity date.*

"Related Bond Indenture" means any bond indenture, bond resolution or similar instrument pursuant to which a series of Related Bonds is issued.

"Related Bonds" means any revenue bonds or similar obligations issued by any state, commonwealth or territory of the United States or any municipal corporation or other political subdivision formed under the laws thereof or any constituted authority, agency or instrumentality of any of the foregoing empowered to issue obligations on behalf thereof, the proceeds of which are loaned or otherwise made available to any Credit Group Member in consideration, whether in whole or in part, of the execution, authentication and delivery of an Obligation or Obligations to such governmental issuer.

"Related Bond Trustee" means the trustee appointed under any Related Bond Indenture and any successor trustee thereunder or, if no trustee is appointed under a Related Bond Indenture, the Related Issuer.

"Related Issuer" means the issuer of a series of Related Bonds.

"Related Loan Document" means any document or documents (including without limitation any lease, sublease or installment sales contract) pursuant to which any proceeds of any Related Bonds are advanced to any Credit Group Member (or any Property financed or refinanced with such proceeds is leased, sublet or sold to a Credit Group Member).

"Revenues" means, for any period, the revenues of a Person, as determined in accordance with generally accepted accounting principles; but excluding (i) any unrealized gain or loss resulting from changes in the value of investment securities including any Interest Rate Agreement, or (ii) earnings resulting from any reappraisal, revaluation or write-up of fixed or capital assets; provided, however, that if such calculation is being made with respect to the Credit Group, such calculation shall be made in such a manner so as to exclude any revenues attributable to transactions between any Credit Group Member and any other Credit Group Member.

"Security Agreement" means the Security Agreement dated as of October 1, 1998, as amended by a First Amendment to Security Agreement dated as of October 1, 2007, as further amended by a Second Amendment to Security Agreement dated as of June 1, 2008, as further amended by a Third Amendment to Security Agreement dated as of November 1, 2009, as further amended by a Fourth Amendment to Security Agreement dated as of December 1, 2014, as further amended by a Fifth Amendment to Security Agreement dated as of September 1, 2015, all between the Corporation and the Master Trustee.

"Series 2015 Obligation" shall mean the Allina Health System Direct Note Obligation, Series 2015, to be issued under the Twentieth Supplemental Indenture.

"Short-Term," when used in connection with Indebtedness, means Indebtedness of a Person for money borrowed or credit extended having an original maturity less than or equal to one year and not renewable at the option of the debtor for, or subject to any binding commitment to refinance or otherwise provide for such Indebtedness having, a term greater than one year beyond the date of original issuance; provided that if such

* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

Indebtedness is commercial paper (so long as such commercial paper continues to be remarketed and has an underlying debt service schedule that meets the requirements of Funded Indebtedness) or is incurred for capital improvements it shall not be treated as "Short-Term."

"Standard & Poor's" means Standard & Poor's, a division of The McGraw-Hill Companies, Inc., its successors and assigns, and, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Corporation by notice to the Master Trustee.

"Supplemental Master Indenture" means an indenture amending or supplementing the Master Indenture entered into pursuant to Article VII thereof after the date thereof.

"Tax-Exempt Organization" means a Person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal income taxation under Section 501(a) of the Code, and which is not a "private foundation" within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

"Twentieth Supplemental Trust Indenture" means Twentieth Supplemental Master Indenture, as the same may be amended or supplemented from time to time in accordance with the provisions of the Master Trust Indenture.

"Unlimited Credit Group Participant" means a Person identified by the Obligated Group Agent to the Master Trustee with whom an Obligated Group Member, a Designated Affiliate or a Limited Designated Affiliate has entered into a contract or other agreement, under which such Person is obligated to make all of the payments required by Section 401 of the Master Indenture, perform all of the other obligations of a Credit Group Member of the Master Indenture, and do all things necessary to permit the Obligated Group to perform its obligations and covenants of the Master Indenture, provided that together with such identification there be delivered to the Master Trustee (a) a fully executed copy of such contract or other agreement and (b) an opinion of Counsel to the effect that such contract or other agreement is a valid and binding obligation of such Person enforceable in accordance with its terms, subject to customary exceptions for bankruptcy, insolvency and other laws generally affecting enforcement of creditors' rights and application of general principles of equity and to the exceptions set forth in Exhibit A to the Master Indenture; provided further that each amendment or supplement to the original contract or other agreement and an opinion of Counsel as described in clause (b) with respect to such contract or other agreement, as amended or supplemented, shall also be delivered to the Master Trustee.

"*Unrestricted Net Assets*" means the unrestricted net asset of any Person, if such Person is a non-profit corporation, the shareholders' equity of any Person, if such Person is a for-profit corporation, or the net worth of any other Person, if such Person is not a corporation, as shall be determined in accordance with generally accepted accounting principles. Unless otherwise specifically stated in the Master Indenture, the term "Unrestricted Net Assets" shall refer to the combined or consolidated Unrestricted Net Assets of each member of the Obligated Group.*

"Written Request" means a request in writing signed by the President or any Vice President of a Credit Group Member, or any other officers designated by such Credit Group Member.

* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

SUMMARY OF THE MASTER INDENTURE

The following is a brief description of the Master Indenture as amended and supplemented by the Twentieth Supplemental Master Indenture. By the Twentieth Supplemental Master Indenture certain terms of the Master Indenture are amended to add to the covenants contained in the Master Indenture so long as the Bonds are Outstanding under the Bond Indenture (and unless waived by the Bond Trustee in its sole discretion). The exercise by the Master Trustee of any rights or remedies in the event of a failure by the Obligated Group to comply with any of the covenants and agreements added by the Twentieth Supplemental Indenture shall be subject to the prior approval of the Bond Trustee, and the Bond Trustee may direct the Master Trustee as to the enforcement of all rights and remedies of the Master Trustee under the Master Indenture upon the failure of the Obligated Group to comply with any of the covenants and agreements added by the Twentieth Supplemental Master Indenture. This description shall apply so long as the Bonds are Outstanding under the Bond Indenture. Such description does not purport to be comprehensive or definitive. All references herein to the Master Indenture and Twentieth Supplemental Master Indenture and the terms thereof are qualified in their entirety by reference to the same, copies of which are available for review prior to the issuance and delivery of the Bonds at the offices of the Corporation and thereafter at the offices of the Master Trustee.

The Obligations; Payment of the Obligations

The total principal amount of the Obligations and the number and series of Obligations that may be created under the Master Indenture are not limited. Each series of Obligations shall be issued pursuant to a Supplemental Master Indenture.

The Obligations are intended to be the joint and several obligation of each member of the Obligated Group. The Corporation will initially be the only Obligated Group Member. See "SECURITY FOR THE BONDS – Limitations on Enforceability" in the forepart of this Offering Memorandum.. Any Credit Group Member may incur additional Indebtedness (which, with respect to Obligated Group Members, may include additional Obligations). Such additional Indebtedness may be secured by security in addition to any security provided for the Obligations or any other Indebtedness (including without limitation, letters or lines of credit, insurance or Liens on the Property, including Facilities or Property, of the Members of the Credit Group or security interests in depreciation reserve, debt service or interest reserve or debt service or similar funds). Such security need not be extended to any other Indebtedness (including the Obligations or any other series of Obligations). See "LIENS ON PROPERTY; RIGHT OF CONTEST" below and "DEFINITIONS OF CERTAIN TERMS IN THE MASTER INDENTURE AND THE SECURITY AGREEMENT – Permitted Encumbrances" in this Appendix C. The Master Indenture provides that Supplemental Master Indentures pursuant to which one or more series of Obligations entitled to additional security is issued may provide for such supplements or amendments to the provisions of the Master Indenture, including for the purpose of providing for the issuance of Obligations and to assign and pledge under the Master Indenture any additional revenues, properties or collateral.

Each Obligated Group Member unconditionally and irrevocably jointly and severally agrees that it will promptly pay the principal of and interest, premium, if any, on, and the tender purchase price of the Obligations when due. If any Obligated Group Member does not make payment of any installment of principal, premium or interest on any Obligation, or the purchase price of any Obligation, when due and payable, the Master Trustee shall provide prompt written notice of each nonpayment to each Obligated Group Member and the Obligated Group Agent.

Each Obligated Group Member shall cause each Designated Affiliate and each Limited Designated Affiliate it controls and each Unlimited Credit Group Participant and Limited Credit Group Participant with which it has entered into a contract or agreement to pay or otherwise transfer to the Obligated Group Agent or other Obligated Group Member such amounts as are necessary to duly and punctually pay the principal of and interest, premium, if any, on, and the tender purchase price of all Outstanding Obligations, and any other amounts payable by the Obligated Group Members under the Master Indenture, on the dates, at the times, at the places and in the manner provided in such Obligations (subject, in the case of any Limited Credit Group Participant, to contractual limitations). In addition, each Obligated Group Member shall cause each Designated Affiliate and each Limited Designated Affiliate which it controls to cause each Unlimited Credit Group Participant and Limited Credit Group

Participant with which the Designated Affiliate or Limited Designated Affiliate has entered into a contract or agreement to pay or otherwise transfer such amounts to the Obligated Group Agent (subject, in the case of any Limited Credit Group Participant, to contractual limitations).

Each Obligated Group Member covenants that it will cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which the Obligated Group Member maintains a contract or agreement to comply with the terms and conditions of the Master Indenture which are applicable to such Person. In addition, each Obligated Group Member covenants that it will cause each Designated Affiliate and each Limited Designated Affiliate under its control to cause each Limited Credit Group Participant and Unlimited Credit Group Participant with which such Designated Affiliate or Limited Designated Affiliate maintains a contract or agreement to comply with the terms and provisions of the Master Indenture which are applicable to such Participant.

The Master Indenture provides that, any of the other provisions thereof notwithstanding, it is expressly agreed by the parties thereto that no Credit Group Member other than the Obligated Group Members shall be directly obligated to make any payment thereunder.

The Credit Group

The Credit Group shall consist of each Obligated Group Member, each Limited Credit Group Participant, each Unlimited Credit Group Participant, each Designated Affiliate and each Limited Designated Affiliate. The Obligated Group Agent shall at all times maintain with the Master Trustee an accurate and complete list of all Credit Group Members by category. The Obligated Group Agent may identify (i) any Person which meets the requirements of the definition of an "Unlimited Credit Group Participant" as an Unlimited Credit Group Participant, (ii) any Person which meets the requirements of the definition of a "Limited Credit Group Participant" as a Limited Credit Group Participant, (iii) any Person which meets the requirements of the definition of a "Designated Affiliate" as a Designated Affiliate, and (iv) any Person which meets the requirements of the definition of a "Limited Designated Affiliate" as a Limited Designated Affiliate, in each case by filing a written notice with the Master Trustee. Such notice shall be filed prior to the date such identification is to become effective, with such Person to be deemed a Credit Group Member as of the date specified in such notice. Such Person shall thereafter be considered a Credit Group Member until such time as the Obligated Group Agent shall file with the Master Trustee (i) a notice declaring that such Person is no longer a Credit Group Member effective as of the date of filing or, if later, as of the date specified in the notice, and (ii) a certificate of the Obligated Group Agent to the effect that immediately after the withdrawal of such Person from the Credit Group no event will have occurred which with the passage of time or the giving of notice, or both, would become an event of default under the Master Indenture.

Entrance into the Obligated Group

Any Person may become an Obligated Group Member if:

(a) Such Person shall execute and deliver to the Master Trustee a Supplemental Master Indenture which shall also be executed by the Master Trustee and the Obligated Group Agent on behalf of each then-current Obligated Group Member, containing (i) the agreement of such Person to become an Obligated Group Member and thereby to become subject to compliance with all provisions of the Master Indenture, and unconditionally and irrevocably (subject to the right of such Person to cease its status as an Obligated Group Member pursuant to the terms and conditions of the Master Indenture summarized under the caption "CESSATION OF STATUS AS AN OBLIGATED GROUP MEMBER" below) to jointly and severally make payments upon each Obligation at the times and in the amounts provided in each such Obligation, and (ii) representations and warranties by such Person substantially similar to those set forth in the Master Indenture other than the representation that such Person is a Tax-Exempt Organization if such Person is not a Tax-Exempt Organization, and except that any representation regarding incorporation and good standing shall refer to the actual type and state of organization of such Person;

(b) The Obligated Group Agent shall, by appropriate action of its Governing Body, have approved the admission of such Person to the Obligated Group;

(c) The Master Trustee shall have received (i) a certificate of the Obligated Group Agent to the effect that prior to and immediately after such admission, no event of default exists under the Master Indenture and no event shall have occurred which with the passage of time or the giving of notice, or both, would become such an event of default, (ii) an opinion of Counsel to the effect that (A) the instrument described in paragraph (a) above has been duly authorized, executed and delivered and constitutes a legal, valid and binding agreement of such Person, enforceable in accordance with its terns, subject to customary exceptions for bankruptcy, insolvency and other laws generally affecting enforcement of creditors' rights and application of general principles of equity and to the exceptions set forth in Exhibit A to the Master Indenture, (B) the addition of such Person to the Obligated Group will not adversely affect the status as a Tax-Exempt Organization of any Obligated Group Member which otherwise has such status, (C) the Person which is to become an Obligated Group Member is liable on all Obligations outstanding under the Master Indenture, as if such Obligations were originally issued by such Person, subject only to the applicable exceptions set forth in Exhibit A to the Master Indenture, and (D) under then existing law such Person becoming an Obligated Group Member will not subject any Obligation to the registration provisions of the Securities Act of 1933, as amended (or that such Obligations have been so registered if registration is required), and (iii) if all amounts due or to become due on all Related Bonds have not been paid to the holders thereof and provision for such payment has not been made in such manner as to have resulted in the defeasance of all Related Bond Indentures, an Opinion of Bond Counsel to the effect that under then existing law the addition of such Person as an Obligated Group Member would not adversely affect the validity of any Related Bond or any exemption from federal or state income taxation of interest payable on such Related Bond otherwise entitled to such exemption;

(d) The Master Indenture is amended to add such Person as an Obligated Group Member; and

(e) Such Person shall execute and deliver to the Master Trustee a Security Agreement in substantially the same form as the Security Agreement dated as of October 1, 1998, between the Corporation and the Master Trustee, as amended by the First Amendment to Security Agreement, dated as of October 1, 2007, as further amended as of June 1, 2008 and November 1, 2009, between the Corporation and the Master Trustee, as the same may be amended or supplemented from time to time in accordance with the terms thereof, granting to the Master Trustee a security interest on its "Pledged Revenues" as defined therein.*

Cessation of Status as an Obligated Group Member

Each Obligated Group Member covenants that it will not take any action, corporate or otherwise, which would cause it or any successor thereto into which it is merged or consolidated under the terms of the Master Indenture to cease to be an Obligated Group Member except in accordance with the provisions of the Master Indenture summarized under this caption. An Obligated Group Member may cease to be an Obligated Group Member if:

(a) the Obligated Group Member proposing to withdraw from the Obligated Group is a party to any Related Loan Documents with respect to Related Bonds which remain outstanding, another Obligated Group Member shall issue an Obligation under the Master Indenture evidencing or assuming the obligation of the withdrawing Obligated Group Member in respect of such Related Bonds;

(b) prior to cessation of such status, there is delivered to the Master Trustee an Opinion of Bond Counsel to the effect that, under then existing law, the cessation by the Obligated Group Member of its status as an Obligated Group Member will not adversely affect the validity of any Related Bond or any exemption from federal or state income taxation of interest payable thereon to which such Related Bond would otherwise be entitled;

* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

(c) the Master Trustee shall have received a certificate of the Obligated Group Agent to the effect that prior to and immediately after such cessation, no event of default exists under the Master Indenture and no event shall have occurred which with the passage of time or the giving of notice, or both, would become an event of default;

(d) prior to such cessation there is delivered to the Master Trustee an opinion of Counsel to the effect that the cessation by such Obligated Group Member of its status as an Obligated Group Member will not adversely affect the status as a Tax-Exempt Organization of any Obligated Group Member which otherwise has such status;

(e) prior to such cessation of such status, the Obligated Group Agent consents in writing to the withdrawal of such Obligated Group Member; and

(f) prior to such cessation there is delivered to the Master Trustee an opinion of Counsel to the effect that the Obligation issued under subsection (a) to evidence or assume the obligation of the withdrawing Obligated Group Member is valid and binding upon the Obligated Group Member issuing the Obligation and enforceable upon its terms, subject to bankruptcy and similar creditors' remedies.

Substitution of Obligations

In the event any Obligated Group Member ceases to be a Member of the Obligated Group in accordance and compliance with the provisions of the Master Indenture summarized under the caption "CESSATION OF STATUS AS AN OBLIGATED GROUP MEMBER" above, and another Obligated Group Member issues an Obligation under the Master Indenture, the original Obligation shall be surrendered to the Master Trustee in exchange for a substitute Obligation (without, in the case of any obligation issued to secure a series of Related Bonds, notice to or consent of any Related Bondholder), provided that such substitute Obligation provides for payments of principal, interest, premium and other amounts identical to the surrendered Obligation.

Substitution of Obligations under Substitute Master Indenture

All Obligations issued under the Master Indenture (unless specifically provided to the contrary in any Supplemental Master Indenture creating a particular series of Obligations) are issued on the condition that the Corporation, in its sole discretion, may substitute for any Obligation a new note issued under a different master trust indenture (a "Substitute Master Indenture") should the Corporation or any other then member of the Obligated Group become members of the obligated group created by the Substitute Master Indenture (the "Substitute Obligated Group"). No substitution will be effective unless the Master Trustee has received (i) written confirmation from at least one national rating agency at the Corporation's request that, upon consummation of the proposed transactions, the rating on the Related Bonds will not be lower than the rating then in effect without taking into account modifiers within a rating category, (ii) an Opinion of Bond Counsel to the effect that the proposed transactions will not adversely affect any applicable exemption from federal income taxation of the interest payable on any outstanding Related Bonds, and (iii) an unconditional assumption of the indebtedness represented by all Outstanding Obligations by the members of the Substitute Obligated Group and an opinion of Counsel to the effect that the assumption is a valid and binding obligation of the Substitute Obligated Group, enforceable in accordance with its terms, subject to normal exceptions for bankruptcy matters and the availability of equitable remedies. Upon satisfaction of the conditions set forth above, the Master Trustee will request all then current Obligations Holders, including any Related Bond Trustee, to return their Obligations to the Master Trustee for cancellation in exchange for a new note issued under the Substitute Master Indenture and the Holders agree, upon such a request and exchange, to deliver their Obligations to the Master Trustee.

Rates and Charges

Each Obligated Group Member covenants and agrees to, and each Obligated Group Member covenants to cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or any Limited Designated Affiliate under its control maintains a contract or agreement to, conduct its business on a revenue-

producing basis and to charge such fees and rates and to exercise such skill and diligence as to provide income from its Property, together with other available funds, sufficient to pay promptly all payments due on the Obligations, all expenses of operation, maintenance and repair of its Property and all other payments required to be made by it under the Master Indenture to the extent permitted by law. Each Obligated Group Member further covenants and agrees that it will, and each Obligated Group Member covenants that it will cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or any Limited Designated Affiliate under its control maintains a contract or agreement to, from time to time as often as necessary and to the extent permitted by law, revise its rates, fees and charges in such manner as may be necessary or proper to comply with the provisions of the Master Indenture summarized under this caption.

The Obligated Group Agent shall calculate the Historical Debt Service Coverage Ratio of the Credit Group for each Fiscal Year and deliver a copy of such calculations to the Persons to the Master Trustee within one hundred fifty (150) days after the end of the Fiscal Year.

If in any such Fiscal Year the Historical Debt Service Coverage Ratio of the Credit Group is less than 1.10 to l, the Master Trustee shall require the Obligated Group Agent at its expense to retain a Consultant to make recommendations with respect to the rates, fees and charges of the Credit Group and the Credit Group Members' methods of operation and other factors affecting its financial condition in order to increase such Historical Debt Service Coverage Ratio for the succeeding Fiscal Year to at least 1.10 to l.

A copy of the Consultant's report and recommendations, if any, shall be filed with each Credit Group Member, the Master Trustee and each Related Bond Trustee. Each Obligated Group Member shall follow, and each Obligated Group Member shall cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to follow the recommendations of the Consultant applicable to it to the extent feasible (as determined in the reasonable judgment of the Governing Body of such Obligated Group Member) and permitted by law, subject in the case of a Limited Credit Group Participant to the terms of its contract or agreement. The provisions of the Master Indenture summarized under this caption shall not be construed to prohibit any Credit Group Member from serving indigent patients to the extent required for such Member to continue its qualification as a Tax-Exempt Organization or from serving any other class or classes of patients without charge or at reduced rates so long as such service does not prevent the Credit Group from satisfying the other requirements of the provisions of the Master Indenture summarized under this caption.

The foregoing provisions notwithstanding, if in any such Fiscal Year the Historical Debt Service Coverage Ratio of the Credit Group is less than 1.10 to 1, the Master Trustee shall not be obligated to require the Obligated Group Agent to retain a Consultant to make such recommendations if: (a) there is filed with the Master Trustee (who shall provide a copy to each Related Bond Trustee) a written report addressed to them by a Consultant which contains an opinion of such Consultant that applicable laws or regulations have prevented the Credit Group from generating Income Available for Debt Service during such Fiscal Year in an amount sufficient to produce a Historical Debt Service Coverage Ratio of the Credit Group of 1.10 to 1 or higher, and, if requested by the Master Trustee, such report is accompanied by a concurring opinion of Counsel as to any conclusions of law supporting the report of such Consultant; (b) the report of such Consultant indicates that the fees and rates charged by the Credit Group Members are such that, in the opinion of the Consultant, the Credit Group has generated the maximum amount of Revenues reasonably practicable given such laws or regulations; and (c) the Historical Debt Service Coverage Ratio of the Credit Group was at least 1.00 to 1 for such Fiscal Year. The Obligated Group Agent shall not be required to cause the Consultant's report referred to in the preceding sentence to be prepared more frequently than once every two Fiscal Years if at the end of the first of such two Fiscal Years the Obligated Group Agent provides to the Master Trustee (who shall provide a copy to each Related Bond Trustee) an opinion of Counsel to the effect that the applicable laws and regulations underlying the Consultant's report delivered in respect of the previous Fiscal Year have not changed in any material way.

The Obligated Group covenants that it shall maintain an Historical Debt Service Coverage Ratio of the Obligated Group for each Fiscal Year of at least 1.00 to 1. Failure to maintain such Historical Debt Service Coverage Ratio shall not constitute an Event of Default under the Master Indenture for a period of one year,

provided that during such year the Obligated Group maintains Days Cash on Hand of at least 75 days. After the expiration of one year or Days Cash on Hand falling below 75 days, the failure to maintain an Historical Debt Service Coverage Ratio of the Obligated Group for each Fiscal Year of at least 1.00 to 1 shall constitute an immediate Event of Default under the Master Indenture, unless as of the end of such Fiscal Year (i) the Obligated Group's Days Cash on Hand was at least 75 days and (ii) the Historical Debt Service Coverage Ratio for the prior Fiscal Year was at least 1.00 to 1.*

For purposes of this Section, debt service on Balloon Indebtedness, for purposes of calculating annual Debt Service Requirements on Funded Indebtedness, shall be deemed payable on a level debt service basis over a 25-year amortization.*

Liens on Property; Right of Contest

No Obligated Group Member shall, and no Obligated Group Member shall permit any Designated Affiliate or Limited Designated Affiliate under its control or any Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to, create or incur or permit to be created or incurred or to exist any Lien on any Property of any Credit Group Member to secure Indebtedness except Permitted Encumbrances.

No Credit Group Member shall be required to remove any Lien which is not a Permitted Encumbrance, pay or otherwise satisfy and discharge its obligations, Indebtedness (other than any Obligations), demands and claims against it or to comply with any Lien, law, ordinance, rule, order, decree, decision, regulation or requirement, so long as such Credit Group Member shall contest, in good faith and at its cost and expense, in its own name and behalf, the amount or validity thereof, in an appropriate manner or by appropriate proceedings which shall operate during the pendency thereof to prevent the collection of or other realization upon the obligation, Indebtedness, demand, claim or Lien so contested, and the sale, forfeiture or loss of its Property or any part thereof, provided, that no such contest shall subject any Related Issuer, Related Bond Trustee, Obligation Holder or the Master Trustee to the risk of any liability. While any such matters are pending, such Credit Group Member shall not be required to pay, remove or cause to be discharged the obligation, Indebtedness, demand, claim or Lien being contested unless such Credit Group Member agrees to settle such contest. Each such contest shall be promptly prosecuted to final conclusion (subject to the right of such Credit Group Member engaging in such a contest to settle such contest), and in any event the Obligated Group Member shall save, and each Obligated Group Member agrees to cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to save all Related Issuers, Related Bond Trustees, Obligation Holders and the Master Trustee harmless from and against all losses, judgments, decrees and costs (including reasonable attorneys' fees and expenses in connection therewith) as a result of such contest and will, promptly after the final determination of such contest or settlement thereof, pay and discharge the amounts which shall be determined to be payable therein, together with all penalties, fines, interests, costs and expenses thereon or incurred in connection therewith. The Credit Group Member engaging in such a contest shall give the Master Trustee prompt written notice of any such contest. Pursuant to the Master Indenture, each Obligated Group Member waives and each Obligated Group Member agrees to cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or any Limited Designated Affiliate under its control maintains a contract or agreement to waive, to the extent permitted by law, any right which it may have to contest (i) any Obligation issued for the benefit of another Obligated Group Member or (ii) any Obligation issued to secure or in connection with Related Bonds.

If the Master Trustee shall notify a Credit Group Member that, in the opinion of Counsel, by nonpayment of or noncompliance with any of the foregoing obligations the Property of such Credit Group Member or any substantial part thereof will be subject to imminent loss or forfeiture, then such Obligated Group Member shall promptly pay, and shall cause each Designated Affiliate and each Limited Designated Affiliate under its control and

* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to promptly pay, all such unpaid items and cause them to be satisfied and discharged.

Insurance

Each Obligated Group Member covenants and agrees to, and each Obligated Group Member covenants to cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to, maintain or cause to be maintained at its sole cost and expense, insurance (which may be self-insurance) with respect to its Property, the operation thereof and its business against such casualties, contingencies and risks (including but not limited to public liability and employee dishonesty) and in amounts not less than is customary in the case of corporations engaged in the same or similar activities and similarly situated and as is adequate to protect its Property and operations.

Sale, Lease Or Other Disposition Of Property*

Any Obligated Group Member may not during any Fiscal Year sell, lease, transfer or otherwise dispose (including without limitation any involuntary disposition) of Property to any Person which is not an Obligated Group Member, the Book Value of which Property (determined as of the date of such sale, lease, transfer or disposition) when added to the Book Value of all other Property transferred by the Obligated Group Members during such Fiscal Year to a Person which is not an Obligated Group Member would exceed three percent (3%) of the Revenues of the Obligated Group as of the most recently completed Fiscal Year other than:

(a) transfers of Property in the ordinary course of business, or otherwise upon fair and reasonable terms no less favorable than would be obtained in a comparable arm's length transaction; or

(b) transfers of Property to any Person if (i) prior to such transfer, the Trustee receives an Officer's Certificate of the Corporation (on behalf of the Obligated Group) in a form acceptable to the Trustee stating that such Property has become or within the next succeeding 12 calendar months is expected to become inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary and the disposition thereof will not impair the structural soundness, efficiency or economic value of the remaining Property, or (ii) the Obligated Group Member transferring such Property acquires and substitutes for the Property transferred other Property of substantially equivalent utility to that so transferred; or

(c) transfers of Property if (i) the Historical Debt Service Coverage Ratio of the Obligated Group as of the end of the most recent Fiscal Year exceeded 2.50 to 1, (ii) the Historical Debt Service Coverage Ration of the Obligated Group as of the end of the most recent Fiscal Year calculated after giving effect to such sale, lease, transfer or disposition is at least 1.10 to 1.00 and shall not have declined by more than 25% as compared to the Historical Debt Service Coverage Ratio calculated without giving effect to such transaction, or (iii) the Unrestricted Net Assets of the Obligated Group calculated after giving effect to such sale, lease, transfer or disposition shall not be less than 95% of the Unrestricted Net Assets of the Obligated Group immediately prior to such transaction..

Merger, Consolidation, Sale or Conveyance

(a) Each Obligated Group Member agrees that it will not merge into, or consolidate with, one or more corporations which are not Obligated Group Members, or allow one or more of such corporations to merge into it, or sell or convey all or substantially all of its Property to any Person who is not an Obligated Group Member, unless:

(i) Any successor corporation to such Obligated Group Member (including without limitation any purchaser of all or substantially all the Property of such Obligated Group Member) is a corporation organized and existing under the laws of the United States of America or a state thereof and shall execute and deliver to the Master Trustee an appropriate instrument, containing the agreement of such successor corporation to assume, jointly and severally, the due and punctual payment of the principal of and interest, premium, if any, on, and the purchase price of, all Obligations according to their tenor and the

* Temporary amendment to the Master Trust Indenture under the Twentieth Supplemental Indenture waivable by the Trustee.

due and punctual performance and observance of all the covenants and conditions of the Master Indenture to be kept and performed by such Obligated Group Member;

(ii) Immediately after such merger or consolidation, or such sale or conveyance, no Obligated Group Member would be in default in the performance or observance of any covenant or condition of any Related Loan Document or the Master Indenture and the Master Trustee shall receive an Officer's Certificate of the Obligated Group Agent to such effect;

(iii) The Master Trustee receives an opinion of Counsel to the effect that (a) such consolidation, merger, conveyance or transfer and any such assumption and Supplemental Master Indenture delivered in connection therewith comply with the requirements described in the provisions of the Master Indenture; (b) all conditions precedent to such transaction have been complied with; (c) the Person which is the surviving entity meets the conditions contained in the Master Indenture and is liable on all Obligations Outstanding under the Master Indenture, as if such Obligations were originally issued by such Person; and (d) under then existing law such merger, consolidation, sale or conveyance will not subject any Obligations to the registration provisions of the Securities Act of 1933, as amended (or that such Obligations have been so registered if registration is required); and

(iv) If all amounts due or to become due on all Related Bonds have not been fully paid to the holders thereof or fully provided for, there shall be delivered to the Master Trustee an Opinion of Bond Counsel to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance would not adversely affect the validity of such Related Bonds or the exemption otherwise available from federal or state income taxation of interest payable on such Related Bonds.

(b) In case of any such consolidation, merger, sale or conveyance and upon any such assumption by the successor corporation, such successor corporation shall succeed to and be substituted for its predecessor, with the same effect as if it had been named in the Master Indenture as such Obligated Group Member and the Obligated Group Member which is a party to such transaction, if it is not the survivor, shall thereupon be relieved of any further obligation or liabilities under the Master Indenture or upon the Obligations and such Obligated Group Member as the predecessor or non-surviving corporation may thereupon or at any time thereafter be dissolved, wound up or liquidated. Any successor corporation to such Obligated Group Member thereupon may cause to be signed and may issue in its own name Obligations under the Master Indenture. All Obligations so issued by such successor corporation under the Master Indenture shall in all respects have the same legal rank and benefit under the Master Indenture as Obligations theretofore or thereafter issued in accordance with the terms of the Master Indenture as though all of such Obligations had been issued under the Master Indenture by such prior Obligated Group Member without any such consolidation, merger, sale or conveyance having occurred.

(c) In case of any such consolidation, merger, sale or conveyance such changes in phraseology and form (but not in substance) may be made in Obligations thereafter to be issued as may be appropriate.

(d) Any such consolidation, merger, sale or conveyance shall be on such terms as shall fully preserve the right and powers of the Master Trustee and the owners of the Obligations.

(e) Except as may be expressly provided in any Supplemental Master Indenture, the ability of any Limited Credit Group Participant, Unlimited Credit Group Participant, Designated Affiliate or Limited Designated Affiliate to merge into, or consolidate with, one or more corporations, or allow one or more corporations to merge into it, or sell or convey all or substantively all of its Property to any Person is not limited by the provisions of the Master Indenture.

Financial Statements

(a) Each Obligated Group Member covenants that it will and will cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement to (i) keep or cause to be kept proper books of records and accounts in which full, true and

correct entries will be made of all dealings or transactions of or in relation to its business and affairs in accordance with generally accepted accounting principles consistently applied, except as may be disclosed in the notes to the audited financial statements hereinafter referred to, and (ii) deliver to the Obligated Group Agent within 120 days after the end of the Fiscal Year of such Obligated Group Member, Designated Affiliate, Limited Designated Affiliate, Unlimited Credit Group Participant or Limited Credit Group Participant, as the case may be, audited financial statements of, or including the operations of, such Obligated Group Member, Designated Affiliate, Limited Designated Affiliate, Unlimited Credit Group Participant or Limited Credit Group Participant. The foregoing notwithstanding, the financial condition and results of operations of a Limited Credit Group Participant need not be audited provided that (i) the revenues of such Limited Credit Group Participant represent 5% or less of the Revenues of the Credit Group for such Fiscal Year and (ii) the aggregate revenues of all Limited Credit Group Participants described in (1) represent 15% or less of Revenues of the Credit Group for such Fiscal Year.

(b) The Obligated Group Agent shall prepare an Officer's Certificate within one hundred and fifty (150) days after the end of each Fiscal Year (i) setting forth the calculation of the Historical Debt Service Coverage Ratio of the Credit Group for the reported Fiscal Year, and (ii) stating that (x) a review of the activities of the Credit Group during the reported Fiscal Year and of performance under the Master Indenture has been made under the supervision of the Obligated Group Agent, and (y) to the best of the signer's knowledge, based on such review, the Credit Group has fulfilled all its obligations under the Master Indenture throughout such Fiscal Year or, if there has been a default in the fulfillment of any such obligation, specifying each such default known to the signer and the nature and status thereof and shall provide such Officer's Certificate to the Master Trustee.

The Obligated Group Agent shall also provide to the Master Trustee a then-current list of the Obligated Group Members, the Limited Credit Group Participants, the Unlimited Credit Group Participants, the Designated Affiliates and Limited Designated Affiliate within one hundred and fifty (150) days after the end of each Fiscal Year.

(c) If an event of default under the Master Indenture has occurred, but only in such case, the Obligated Group Members shall provide such additional information as the Master Trustee or any Related Bond Trustee may reasonably request concerning any Credit Group Member in order to enable the Master Trustee or such Related Bond Trustee to determine whether the covenants, terms and provisions of the Master Indenture have been complied with by the Credit Group Members.

Permitted Additional Indebtedness

Except as may be expressly provided in any Supplemental Master Indenture, the ability of any Credit Group Member to incur Indebtedness including, with respect to Obligated Group Members, Indebtedness evidenced by Obligations and the amount and terms of such Indebtedness, is not limited by the provisions of the Master Indenture.

Other Covenants of the Members

Each Obligated Group Member covenants to, and each Obligated Group Member covenants to cause each Designated Affiliate and each Limited Designated Affiliate under its control and each Limited Credit Group Participant or Unlimited Credit Group Participant with which it or any Designated Affiliate or Limited Designated Affiliate under its control maintains a contract or agreement:

(a) Except as otherwise expressly provided in the Master Indenture (i) subject to the provisions of the Master Indenture summarized in paragraph (b) under the caption "MERGER, CONSOLIDATION, SALE OR CONVEYANCE" above, preserve its corporate or other separate legal existence, and (ii) be qualified to do business and conduct its affairs in each jurisdiction where its ownership of Property or the conduct of its business or affairs requires such qualification.

(b) Promptly pay or otherwise satisfy and discharge all of its obligations and Indebtedness and all demands and claims against it as and when the same become due and payable which if not so paid, satisfied or discharged would constitute a default or an event of default under the provisions of the Master Indenture summarized under subparagraph (c) of the caption "DEFAULTS AND REMEDIES" below.

(c) At all times comply with all terms, covenants and provisions of any Liens at such time existing upon its Property or any part thereof or securing any of its Indebtedness.

(d) In the case of any Person which is a Tax-Exempt Organization at the time it becomes a Credit Group Member, so long as all amounts due or to become due on all Related Bonds have not been fully paid to the holders thereof or provision for such payment has not been made, to take no action or suffer any action to be taken by others, including any action which would result in the alteration or loss of its status as a Tax-Exempt Organization, which could result in any such Related Bond being declared invalid or result in the interest on any Related Bond, which is otherwise exempt from federal or state income taxation, becoming subject to such taxation.

(e) Operate all of its Facilities so as not to discriminate on a legally impermissible basis.

(f) At its sole cost and expense, promptly comply with all present and future laws, ordinances, orders, decrees, decisions, rules, regulations and requirements of every duly constituted governmental authority, commission and court and the officers thereof which may be applicable to it or any of its affairs, business, operations and Property, any part thereof, any of the streets, alleys, passageways, sidewalks, curbs, gutters, vaults and vault spaces adjoining any of its Property or any part thereof or to the use or manner of use, occupancy or condition of any of its Property or any part thereof.

The foregoing provisions of the Master Indenture notwithstanding, any Credit Group Member may (i) cease to be a nonprofit corporation or (ii) take actions which could result in the alteration or loss of its status as a Tax-Exempt Organization if prior thereto there is delivered to the Master Trustee (1) an Opinion of Bond Counsel to the effect that such actions would not adversely affect the validity of any Related Bond, or the exemption from federal or state income taxation of interest payable on any Related Bond otherwise entitled to such exemption or adversely affect the enforceability in accordance with its terms of the Master Indenture against any Person, and (2) an opinion of Counsel to the effect that under then-existing law such action will not subject any Obligations to the registration provisions of the Securities Act of 1933, as amended (or that such Obligations have been so registered if registration is required).

Defaults and Remedies

The following events are "events of default" under the Master Indenture:

(a) failure of the Obligated Group to pay any installment of interest or principal, or any premium, or purchase price of any Obligation when the same shall become due and payable, whether at maturity, upon any date fixed for prepayment or by acceleration or otherwise and the continuance of the failure for five days, or for such other applicable grace period set forth in the Supplemental Master Indenture pursuant to which such Obligation is issued; or

(b) failure of any Obligated Group Member to comply with, observe or perform any of the covenants, conditions, agreements or provisions of the Master Indenture (other than described in clause (a) above) and to remedy such default within 60 days after written notice thereof to such Obligated Group Member and the Obligated Group Agent from the Master Trustee or the holders of at least 25% in aggregate principal amount of the outstanding Obligations; provided, that if such default cannot with due diligence and dispatch be wholly cured within 60 days but can be wholly cured, the failure of the Obligated Group Member to remedy such default within such 60-day period shall not constitute a default under the Master Indenture if the Obligated Group Member shall commence with due diligence and dispatch the curing of such default and, having so commenced the curing of such default, shall thereafter prosecute and complete the same with due diligence and dispatch; or

(c) default in the payment of the principal of, premium, if any, or interest on any Indebtedness for borrowed money (other than Non-Recourse Indebtedness or any Indebtedness evidenced by an Obligation) of any Obligated Group Member in an amount in excess of 1% of the Revenues of the Credit Group, including without limitation any Indebtedness created by any Related Loan Document, as and when the same shall become due, or an event of default as defined in any mortgage, indenture, loan agreement or other instrument under or pursuant to

which there was issued or incurred, or by which there is secured, any such Indebtedness (including any Obligation) of any Obligated Group Member, and which default in payment or event of default entitles the holder thereof (or a credit enhancer exercising the rights of such holder) to declare or, in the case of any Obligation, to request that the Master Trustee declare, such Indebtedness due and payable prior to the date on which it would otherwise become due and payable; provided, however, that such default shall not constitute an event of default under the Master Indenture if within 30 days, or within the time allowed for service of a responsive pleading if any proceeding to enforce payment of the Indebtedness is commenced (i) the Obligated Group Members in good faith commence proceedings to contest the existence or payment of such Indebtedness, and (ii) sufficient moneys are escrowed with a bank or trust company for the payment of such Indebtedness; or

(d) any Obligated Group Member admits insolvency or bankruptcy or its inability to pay its debts as they mature, or is generally not paying its debts as such debts become due, or makes an assignment for the benefit of creditors or applies for or consents to the appointment of a trustee, custodian or receiver for such Member, or the major part of its Property; or

(e) a trustee, custodian or receiver is appointed for any Obligated Group Member or for a material part of its Property and is not discharged within 60 days of such appointment; or

(f) bankruptcy, dissolution, reorganization, arrangement, insolvency or liquidation proceedings, proceedings under Title 11 of the United States Code, as amended, or other proceedings for relief under any bankruptcy law or similar law for the relief of debtors are instituted by or against any Obligated Group Member (other than bankruptcy proceedings instituted by any Obligated Group Member against third parties), and if instituted against any Obligated Group Member are allowed against such Obligated Group Member or are consented to or are not dismissed, stayed or otherwise nullified within 60 days after such institution; or

(g) any Obligated Group Member admits in writing its inability to pay its debts generally as they become due.

If an event of default has occurred and is continuing, the Master Trustee may, and if requested by the holders of not less than 25% in aggregate principal amount of Outstanding Obligations or the holder of any Accelerable Instrument shall, by notice in writing delivered to the Obligated Group Agent, declare the entire principal amount of all Obligations then outstanding under the Master Indenture and the interest accrued thereon immediately due and payable, and the entire principal and such interest shall thereupon become immediately due and payable, subject, however, to the provisions of the Master Indenture summarized under the caption "WAIVER OF EVENTS OF DEFAULT" below with respect to waivers of events of default.

Upon the occurrence of any event of default under the Master Indenture, the Master Trustee may pursue any available remedy including a suit, action or proceeding at law or in equity to enforce the payment of the principal of, premium, if any, and interest on the Obligations outstanding under the Master Indenture and any other sums due under the Master Indenture and may collect such sums in the manner provided by law out of the Property of any Obligated Group Member wherever situated.

If an event of default shall have occurred, and if it shall have been requested to do so by either the holders of 25% or more in aggregate principal amount of Obligations outstanding or the holder of an Accelerable Instrument upon whose request the Master Trustee has accelerated the Obligations, and if it shall have been indemnified as provided in the Master Indenture, the Master Trustee shall be obligated to exercise such one or more of the rights and powers conferred by the Master Indenture as the Master Trustee shall deem most expedient in the interests of the holders of Obligations; provided, however, that the Master Trustee shall have the right to decline to comply with any such request if the Master Trustee shall be advised by counsel (who may be its own counsel) that the action so requested may not lawfully be taken or the Master Trustee in good faith shall determine that such action would be unjustly prejudicial to the holders of Obligations not parties to such request.

Direction of Proceedings

The holders of 25% or more in aggregate principal amount of the Obligations then outstanding which have become due and payable in accordance with their terms or have been declared due and payable pursuant to the provisions of the Master Indenture and have not been paid in full in the case of remedies exercised to enforce such payment, or the holders of 25% or more in aggregate principal amount of the Obligations then outstanding in the case of any other remedy, shall have the right, at any time, by an instrument or instruments in writing executed and delivered to the Master Trustee, to direct the method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the Master Indenture or for the appointment of a receiver or any other proceedings thereunder; provided, that such direction shall not be otherwise than in accordance with the provisions of law and of the Master Indenture and that the Master Trustee shall have the right to decline to comply with any such request if the Master Trustee shall be advised by counsel (who may be its own counsel) that the action so directed may not lawfully be taken or the Master Trustee in good faith shall determine that such action would be unjustly prejudicial to the holders of the Obligations not parties to such direction. Pending such direction from the requisite holders of the Obligations, such direction may be given in the same manner and with the same effect by the holder of an Accelerable Instrument upon whose request the Master Trustee has accelerated the Obligations.

The foregoing notwithstanding, the holders of 25% or more in aggregate principal amount of the Obligations then outstanding which are entitled to the exclusive benefit of certain security in addition to that intended to secure all or other Obligations shall have the right, at any time, by an instrument or instruments in writing executed and delivered to the Master Trustee, to direct the method and place of conducting all proceedings to be taken in connection with the enforcement of the terms and conditions of the Master Indenture, the Supplemental Master Indenture or Indentures pursuant to which such Obligations were issued or so secured or any separate security document in order to realize on such security; provided, however, that such direction shall not be otherwise than in accordance with the provisions of law and of the Master Indenture.

Rights and Remedies of Obligation Holders

No holder of any Obligation shall have any right to institute any suit, action or proceeding in equity or at law for the enforcement of the Master Indenture or for the execution of any trust under the Master Indenture or for the appointment of a receiver or any other remedy under the Master Indenture, unless a default shall have become an event of default and (a) the holders of 25% or more in aggregate principal amount of (i) the Obligations which have become due and payable in accordance with their terms or have been declared due and payable pursuant to the Master Indenture and have not been paid in full in the case of powers exercised to enforce such payment or (ii) the Obligations then outstanding in the case of any other exercise of power, or (b) the holder of an Accelerable Instrument upon whose request the Master Trustee has accelerated the Obligations, shall have made Written Request to the Master Trustee and shall have offered it reasonable opportunity either to proceed to exercise the powers hereinbefore granted or to institute such action, suit or proceeding in its own name, and unless also, in each case, such holders have offered to the Master Trustee indemnity as provided in the Master Indenture, and unless the Master Trustee shall thereafter fail or refuse to exercise the powers hereinbefore granted, or to institute such action, suit or proceeding in its own name; and such notification, request and offer of indemnity are declared in every case at the option of the Master Trustee to be conditions precedent to the execution of the powers and trusts of the Master Indenture and to any action or cause of action for the enforcement of the Master Indenture, or for the appointment of a receiver or for any other remedy thereunder; it being understood and intended that no one or more holders of the Obligations shall have any right in any manner whatsoever to affect, disturb or prejudice the lien of the Master Indenture or to enforce any right thereunder except in the manner therein provided, and that all proceedings at law or in equity shall be instituted, had and maintained in the manner provided for in the Master Indenture and for the equal benefit of the holders of all Obligations outstanding. Nothing contained in the Master Indenture shall, however, affect or impair the right of any holder to enforce the payment of the principal of, premium, if any, and interest on any Obligation at and after the maturity thereof, or the obligation of the Obligated Group Members to pay the principal, premium, if any, and interest on or tender purchase price of each of the Obligations issued under the Master Indenture to the respective holders thereof at the time and place, from the source and in the manner in said Obligations expressed.

Waiver of Events of Default

If, at any time after the principal of all Obligations shall have been so declared due and payable, and before any judgment or decree for the payment of the moneys due shall have been obtained or entered and before the acceleration of any Related Bond, any Obligated Group Member shall pay or shall deposit with the Master Trustee a sum sufficient to pay all matured installments of interest upon all such Obligations and the principal and premium, if any, of all such Obligations that shall have become due otherwise than by acceleration (with interest on overdue installments of interest and on such principal and premium, if any, at the rate borne by such Obligations to the date of such payment or deposit, to the extent permitted by law) and the reasonable expenses of the Master Trustee, and any and all events of default under the Master Indenture, other than the nonpayment of principal of and accrued interest on such Obligations that shall have become due by acceleration, shall have been remedied, then and in every such case the holders of 25% or more in aggregate principal amount of all Obligations then outstanding and the holder of each Accelerable Instrument who requested the giving of notice of acceleration, by written notice to the Obligated Group Agent and to the Master Trustee, may waive all events of default and rescind and annul such declaration and its consequences; but no such waiver or rescission and annulment shall extend to or affect any subsequent event of default, or shall impair any right consequent thereon.

Supplemental Master Indentures

Subject to the limitations set forth in the next paragraph, the Obligated Group Agent, on behalf of the Obligated Group Members, and the Master Trustee may, without the consent of, or notice to, any of the Obligation Holders, amend or supplement the Master Indenture, for any one or more of the following purposes:

(a) To cure any ambiguity or defective provision in or omission from the Master Indenture in such manner as is not inconsistent with and does not impair the security of the Master Indenture or adversely affect the holder of any Obligation;

(b) To grant to or confer upon the Master Trustee for the benefit of the Obligation Holders any additional rights, remedies, powers or authority that may lawfully be granted to or conferred upon the Obligation Holders and the Master Trustee, or either of them, to add to the covenants of the Obligated Group Members for the benefit of the Obligation Holders or to surrender any right or power conferred under the Master Indenture upon any Obligated Group Member;

(c) To assign and pledge under the Master Indenture any additional revenues, properties or collateral;

(d) To evidence the succession of another corporation to the agreements of an Obligated Group Member or the Master Trustee, or the successor of any thereof under the Master Indenture;

(e) To permit the qualification of the Master Indenture under the Trust Indenture Act of 1939, as then amended, or under any similar federal statute hereafter in effect or to permit the qualification of any Obligations for sale under the securities laws of the United States or any state of the United States;

(f) To provide for the refunding or advance refunding of any Obligation;

(g) To provide for the issuance of Obligations;

(h) To reflect the addition to or withdrawal of an Obligated Group Member from the Obligated Group, including changes to the Exhibits to the Master Indenture;

(i) To provide for the issuance of Obligations with original issue discount, provided such issuance would not materially adversely affect the holders of Outstanding Obligations;

(j) To permit an Obligation to be secured by security which is not extended to all Obligation Holders; and

(k) To make any other change which, in the opinion of the Master Trustee, does not materially adversely affect the holders of any of the Obligations, including without limitation any modification, amendment or supplement to the Master Indenture or any indenture supplemental to the Master Indenture in such a manner as to establish or maintain exemption of interest on any Related Bonds under a Related Bond Indenture from federal income taxation under applicable provisions of the Code.

The holders of a majority in aggregate principal amount of the Obligations which are outstanding under the Master Indenture at the time of the execution of such Supplemental Master Indenture or, in case less than all of the several series of Obligations are affected thereby, the holders of a majority in aggregate principal amount of the Obligations of the series affected thereby which are outstanding under the Master Indenture at the time of the execution of such Supplemental Master Indenture, shall have the right, from time to time, anything contained in the Master Indenture to the contrary notwithstanding, to consent to and approve the execution by the Obligated Group Agent on behalf of the Obligated Group Members and the Master Trustee of such Supplemental Master Indentures as shall be deemed necessary and desirable by the Obligated Group Agent on behalf of the Obligated Group Members for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the Master Indenture or in any Supplemental Master Indenture; provided, however, that nothing contained in the provisions of the Master Indenture summarized under this caption shall permit, or be construed as permitting,

(a) an extension of the stated maturity or reduction in the principal amount of or reduction in the rate or extension of the time of paying of interest on or reduction of any premium payable on the redemption of, any Obligation, without the consent of the holder of such Obligation,

(b) a reduction in the aforesaid aggregate principal amount of Obligations the holders of which are required to consent to any such Supplemental Master Indenture, without the consent of the holders of all the Obligations at the time outstanding which would be affected by the action to be taken,

(c) the creation of any lien ranking prior to or on a parity with the lien of the Master Indenture with respect to the trust estate, if any, subject to the Master Indenture or terminate the lien of the Master Indenture on any Property at any time subject to the Master Indenture or deprive the holder of any Obligation of the security afforded by the lien of the Master Indenture except as otherwise provided in the provisions of the Master Indenture, or

(d) modification of the rights, duties or immunities of the Master Trustee, without the written consent of the Master Trustee.

Related Bond Trustee or Bondholders Deemed to be Obligation Holders; Role of Credit Enhancer

For the purposes of consents, approvals, direction of remedies, appointment or removal of the Master Trustee under the Master Indenture, each Related Bond Trustee shall be deemed the holder of the Obligation or Obligations pledged to secure the Related Bonds with respect to which such Related Bond Trustee is acting as trustee. The foregoing notwithstanding, in the case of any series of Related Bonds supported by credit enhancement, unless contrary provision is made in the related Bond Indenture or unless the credit enhancer is insolvent or has failed to honor its obligations to provide such credit enhancement, the Related Bond Trustee shall exercise such rights as it may have as a holder of an Obligation in accordance with the directions of the credit enhancer.

Removal of Master Trustee

The Master Trustee may be removed at any time, by an instrument or concurrent instruments in writing delivered to the Master Trustee and to the Obligated Group Agent, and signed by the owners of a majority in aggregate principal amount of Obligations then outstanding; provided that, if any Related Issuer so elects, it may sign such an instrument as the holder of the Obligation or Obligations pledged to secure the Related Bonds issued by such Related Issuer. So long as no event of default or event which with the passage of time or giving of notice or both would become such an event of default has occurred and is continuing under the Master Indenture, the Master Trustee may be removed with or without cause at any time by an instrument in writing signed by the Obligated

Group Agent, delivered to the Master Trustee. The foregoing notwithstanding, the Master Trustee may not be removed by the Obligated Group Agent unless written notice of the delivery of such instrument signed by the Obligated Group Agent is mailed to the owners of all Obligations outstanding under the Master Indenture, which notice indicates the Master Trustee will be removed and replaced by the successor trustee named in such notice, such removal and replacement to become effective on the 90th day next succeeding the date of such notice, unless the owners of not less than 10% in aggregate principal amount of such Obligations then outstanding under the Master Indenture shall object in writing to such removal and replacement. Such notice shall be mailed by first class mail, postage prepaid, to the owners of all such Obligations then outstanding at the address of such owners then shown on the Obligations Register.

SUMMARY OF THE SECURITY AGREEMENT

The following is a brief description of the Security Agreement. Such description does not purport to be comprehensive or definitive. All references herein to the Security Agreement and its terms are qualified in their entirety by reference to the same, copies of which are available for review prior to the issuance and delivery of the Bonds at the offices of the Corporation and thereafter at the offices of the Master Trustee.

Grant of Security Interest in Pledged Revenues

By the Security Agreement the Credit Group Members grant to the Master Trustee a security interest in the Pledged Revenues to secure payment of the Obligations and agree to keep all Pledged Revenues free and clear of all security interests, liens and encumbrances except the security interest granted pursuant to the Security Agreement and Permitted Encumbrances and to defend the Pledged Revenues against all claims or demand (other than claims or demands based on Permitted Encumbrances) of all persons other than the Master Trustee.

Pursuant to the Security Agreement, the Credit Group Members and Master Trustee agree that upon the occurrence and continuance of an Event of Default under clauses (a), (d), (e), (f) or (g) described under "SUMMARY OF THE MASTER INDENTURE – Defaults and Remedies," the Master Trustee must (unless both Bond Insurers direct it not to) require in writing directed to each Credit Group Member that all Credit Group Members transfer to the Master Trustee on each Business Day the aggregate amount of the Pledged Revenues of the Credit Group Members collected or received during the prior Business Day for deposit by the Master Trustee in a separate, segregated account. Notwithstanding any provision to the contrary, the Credit Group Members shall comply with any such requirement. The Master Trustee shall apply such amount, as and when received, to the payment of any delinquent Obligations as and when due on a pro rata basis. At its discretion, the Trustee may also release funds held in such account to the Credit Group Members for the purpose of paying Expenses. Upon payment in full of all delinquent principal of, premium, if any, and interest on the Obligations, the Master Trustee shall release to the Credit Group Members any and all moneys and funds then held in such account, and the Credit Group Members shall thereafter be relieved of their obligation to deposit their Pledged Revenues with the Master Trustee as provided in the Security Agreement.

Events of Default

Each of the following occurrences shall constitute an event of default under the Security Agreement: (a) the occurrence of an event of default, as such term is defined in the Master Indenture; (b) any Credit Group Member shall fail to transfer Revenues to the Master Trustee when required pursuant to the Security Agreement, (c) any Credit Group Member shall fail to observe or perform any other covenant or agreement under the Security Agreement and to remedy such default within 60 days after written notice thereof to such Credit Group Member and the Obligated Group Agent from the Master Trustee; provided, that if such default cannot with due diligence and dispatch be wholly cured within 60 days but can be wholly cured, the failure of the Credit Group Member to remedy such default within such 60-day period shall not constitute a default under the Security Agreement if the Credit Group Member shall commence with due diligence and dispatch the curing of such default and, having so commenced the curing of such default, shall thereafter prosecute and complete the same with due diligence and dispatch.

Remedies upon Event of Default

Upon the occurrence and continuance of an event of default under the Security Agreement, the Master Trustee may exercise any one or more of the following rights and remedies: (a) exercise and enforce any or all rights and remedies available upon default to a secured party under the Uniform Commercial Code, including but not limited to the right to take possession of any tangible Pledged Revenues, proceeding without judicial process or by judicial process (without a prior hearing or notice thereof, which each of the Credit Group Members waives), and the right to sell, lease or otherwise dispose of any or all of the Pledged Revenues, and in connection therewith, the Master Trustee may require the Credit Group Members to make the Pledged Revenues available to the Master Trustee at a place to be designated by the Master Trustee which is reasonably convenient to both parties, and if notice to the Credit Group Members of any intended disposition of Pledged Revenues or any other intended action is required by law in a particular instance, such notice shall be deemed commercially reasonable if given at least 10 calendar days prior to the date of intended disposition or other action; and (b) exercise or enforce any or all other rights or remedies available to the Master Trustee by law or agreement against the Pledged Revenues, against the Credit Group Members or against any other person or property.

Amendments, Release and Termination

The Security Agreement shall terminate and the security interest in Pledged Revenues shall be released when the Series 2015 Obligation and all other Obligations secured thereby are no longer Outstanding under the Master Indenture. In addition, the Security Agreement can be waived, modified, amended, terminated or discharged, and the security interest in Pledged Revenues granted thereby can be released prior to such date by writing signed by the Master Trustee with the written consent of the Bond Trustee. The Master Trustee shall execute and deliver financing statement amendments or terminations as may be requested by the Corporation in order to effect the release, waiver, modification, amendment, termination or discharge of the Security Agreement pursuant to the terms of the Security Agreement.

SUMMARY OF THE BOND INDENTURE

The following is a brief description of the Bond Indenture. Such description does not purport to be comprehensive or definitive. All references herein to the Bond Indenture and its terms are qualified in their entirety by reference to the same, copies of which are available for review prior to the issuance and delivery of the Bonds at the offices of the Corporation and thereafter at the offices of the Master Trustee.

Certain Definitions under the Bond Indenture

"Additional Bonds" means bonds issued under the Bond Indenture subsequent to the initial issuance of the Series 2015 Bonds that are consolidated with such bonds.

"Beneficial Owner" means any Person which has or shares the power, directly or indirectly, to make investment decisions concerning ownership of any of the Bonds (including any Person holding Bonds through nominees, depositories or other intermediaries).

"Business Day" means a day that is not a Saturday, Sunday or legal holiday on which banking institutions in (a) the State of New York, and (b) any state in which the offices of the Bond Trustee or Master Trustee are located, are authorized to remain closed, or a day on which The New York Stock Exchange is closed.

"Default" means any event which is or after notice or lapse of time or both would become an Event of Default.

"Event of Default" means any of the events specified as such in the Bond Indenture

"Fitch" means Fitch, Inc., dba Fitch Ratings, a corporation organized and existing under the laws of the State of Delaware, its successors and assigns, or, if such corporation shall be dissolved or liquidated or shall no

longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Obligated Group Agent by notice in writing to the Bond Trustee.

"Interest Payment Date" means each May 15 and November 15, commencing November 15, 2015.

"Make-Whole Redemption Price" means the greater of (1) 100% of the principal amount of any Bonds being redeemed; or (2) the sum of the present values of the remaining scheduled payments of principal and interest on any Bonds being redeemed (exclusive of interest accrued to the date of redemption) discounted to the redemption date on a semiannual basis (assuming a 360-day year consisting of twelve 30-day months) at the Treasury Rate plus 30 basis points.

"Mandatory Sinking Account Payment" means the amount required by the Bond Indenture to be paid on any single date for the retirement of Bonds.

"Member" means a member of the Obligated Group.

"Opinion of Counsel" means a written opinion of counsel (who may be counsel for the Corporation or the Bond Trustee), selected by the Corporation and not objected to by the Bond Trustee. If and to the extent required by the provisions of the Bond Indenture, each Opinion of Counsel shall include the statements provided for in the Bond Indenture.

"Outstanding," when used as of any particular time with reference to Bonds, means (subject to the provisions of the Bond Indenture) all Bonds theretofore, or thereupon being, authenticated and delivered by the Bond Trustee under the Bond Indenture except (a) Bonds theretofore canceled by the Bond Trustee or surrendered to the Bond Trustee for cancellation; (b) Bonds with respect to which all liability of the Corporation shall have been discharged in accordance with the Bond Indenture, including Bonds (or portions of Bonds) referred to in Section 11.09 of the Bond Indenture; and (c) Bonds for the transfer or exchange of or in lieu of or in substitution for which other Bonds shall have been authenticated and delivered by the Bond Trustee pursuant to the Bond Indenture.

"Payment Date" means an Interest Payment Date or a Principal Payment Date.

"Principal Payment Date" means, with respect to any Bond, the date on which principal evidenced by such Bond becomes due and payable, whether at maturity, upon redemption, by declaration of acceleration or otherwise.

"Record Date" means, with respect to any Interest Payment Date, the first day (whether or not a Business Day) of the calendar month in which such Interest Payment Date falls.

"Sinking Account" means each subaccount in the Principal Account so designated and established pursuant to the Bond Indenture.

"Supplemental Bond Indenture" means any indenture hereafter duly authorized and entered into between the Corporation and the Bond Trustee, supplementing, modifying or amending the Bond Indenture; but only if and to the extent that such Supplemental Bond Indenture is specifically authorized under the Bond Indenture.

"Supplemental Indenture" means that certain Twentieth Supplemental Master Indenture, dated as of September 1, 2015, between the Corporation and the Master Trustee.

"United States Government Obligations" means:

(a) direct obligations of the United States of America (including obligations issued or held in book-entry form on the books of the Department of the Treasury of the United States of America) or obligations the timely payment of which are fully guaranteed by the United States of America;

(b) certificates or other instruments that evidence direct ownership of future principal and/or interest on obligations described in clause (1), provided that such obligations are held in the custody of a bank or trust company in a special account separate from the general assets of such custodian; and

(c) obligations (a) the interest on which is excluded from gross income for federal income tax purposes pursuant to Section 103 of the Code, (b) the timely payment of the principal of and interest on which is fully provided for by the deposit in trust or escrow of cash or obligations described in clauses (1) or (2), and (c) that are rated in the highest Rating Category by each Rating Agency then rating both the Bonds and such obligations (but in all cases by at least one Rating Agency then rating the Bonds).

Pledge and Assignment

Under the Bond Indenture, the Corporation pledges and assigns to the Bond Trustee, for the benefit of the Holders from time to time of the Bonds, all of its right, title and interest in and to the Indenture Fund.

Additional Bonds

Additional Bonds may be authorized by a Supplemental Indenture. The Additional Bonds so authorized shall from time to time and in such amounts as directed by the Corporation be authenticated by the Bond Trustee and by it delivered to or upon the order of the Corporation upon receipt of the consideration therefor. All such Additional Bonds shall mature on the maturity date for the Bonds and shall bear interest at the rate per annum for the Bonds. Each Supplemental Indenture authorizing the issuance of Bonds shall specify the following: (a) the authorized principal amount of Additional Bonds to be issued; (b) the purpose for which the Additional Bonds are to be issued; (c) the first Interest Payment Date for the Additional Bonds; (d) directions for the applications of the proceeds of the Additional Bonds; and (e) such other provisions as the Corporation deems advisable.

The Corporation covenants and agrees under the Bond Indenture that (a) Additional Bonds that are consolidated with the Series 2015 Bonds constitute a part of the Bonds; (b) the Additional Bonds shall mature on the same date as the Series 2015 Bonds, bear interest at the same rate per annum as the Series 2015 Bonds, and shall be subject to redemption at the same times and at the same redemption price, including the Make-Whole Redemption Price, if any, as the Series 2015 Bonds; and (c) each Additional Bond to be consolidated with the Series 2015 Bonds shall have the same minimum denominations

As a condition to the issuance of such Additional Bonds the Bond Indenture requires that there shall be delivered to the Bond Trustee a certificate of the Corporation, certifying that, after consultation with counsel experienced in federal securities and tax laws, the issuance and consolidation of such Additional Bonds will not cause (i) any adverse tax impact on the Holders of Outstanding Bonds, (ii) the Outstanding Bonds to be required to be registered under the Securities Act of 1933, as amended or (iii) the Bond Indenture to be required to be qualified under the Trust Indenture Act of 1939, as amended.

Funds and Accounts

There are established by the Bond Indenture in the Indenture Fund, a Bond Fund and a Redemption Fund and each of the accounts contained therein.

All payments received by the Bond Trustee from the Corporation (other than proceeds from the sale of the Bonds or income or profit from investments) with respect to the Series 2015 Obligation are to be deposited in a special fund designated the "Bond Fund" which the Bond Trustee shall establish and maintain and hold in trust and which shall be disbursed and applied only as authorized in the Bond Indenture.

At the times specified below, the Bond Trustee shall allocate within the Bond Fund in the following order of priority the following amounts to the following accounts or funds, each of which the Bond Trustee shall establish and maintain and hold in trust and each of which shall be disbursed and applied only as authorized in the Bond Indenture:

(a) On each Interest Payment Date, the Bond Trustee shall deposit in the "Interest Account" the aggregate amount of interest becoming due and payable on such Interest Payment Date on all Bonds then Outstanding, until the balance in said account is equal to said aggregate amount of interest; and

(b) On each Principal Payment Date, the Bond Trustee shall deposit in the "Principal Account" the aggregate amount of principal becoming due and payable on such Principal Payment Date, until the balance in said account is equal to said aggregate amount of such principal.

(C) At least six (6) but not more than twenty (20) Business Days before each Interest Payment Date, the Bond Trustee shall determine the amount, if any, credited or to be credited to the Bond Fund during the period from the day after the last Interest Payment Date to the next succeeding Interest Payment Date from any source. The Bond Trustee shall give notice to the Corporation of such amount and the amount due, which notice shall be mailed, sent by facsimile transmission or delivered in such manner that the Corporation will receive such notice by the Business Day before such next succeeding Interest Payment Date. Any oral or telephonic notice shall be supplemented by notice given in accordance with the preceding sentence.

(D) The Corporation may at any time surrender to the Bond Trustee for cancellation by it any Bonds that the Corporation may have acquired in any manner whatsoever, and such Bonds, upon such surrender and cancellation, shall be deemed to be paid and retired. All Bonds after such surrender and cancellation shall be destroyed by the Bond Trustee in accordance with its retention policy then in effect.

All amounts in the Interest Account of the Bond Fund are to be used and withdrawn by the Bond Trustee solely for the purpose of paying interest on the Bonds as it shall become due and payable (including accrued interest on any Bonds redeemed prior to maturity pursuant to the Bond Indenture).

All amounts in the Principal Account are to be used and withdrawn by the Bond Trustee solely for the purpose of paying the principal of the Bonds when due and payable, except that all amounts in a Sinking Account shall be used and withdrawn by the Bond Trustee to purchase or redeem or pay at maturity Bonds, as provided in the Bond Indenture.

The Bond Trustee shall establish and maintain within the Principal Account a separate subaccount for the Bonds designated as the "Sinking Account." With respect to the Sinking Account, on the Mandatory Sinking Account Payment date established for the Sinking Account, the Bond Trustee shall transfer the amount deposited in the Principal Account for the purpose of making a Mandatory Sinking Account Payment from the Principal Account to the Sinking Account. On each Mandatory Sinking Account Payment date, the Bond Trustee shall apply the Mandatory Sinking Account Payment required on that date to the redemption (or payment at maturity, as the case may be) of Bonds, upon the notice and in the manner provided in the Bond Indenture; provided that, at any time prior to giving such notice of such redemption, the Bond Trustee shall apply such moneys to the purchase of Bonds at public or private sale, as and when and at such prices (including brokerage and other charges, but excluding accrued interest, which is payable from the Interest Account) as the Corporation may direct, in writing, except that the purchase price (excluding accrued interest) shall not exceed the par amount of such Bonds. If, during the twelve-month period immediately preceding said Mandatory Sinking Account Payment date, the Bond Trustee has purchased Bonds with moneys in the Sinking Account, or, during said period and prior to giving said notice of redemption, the Corporation has deposited Bonds with the Bond Trustee, or Bonds were at any time purchased or redeemed by the Bond Trustee from the Redemption Fund and allocable to the Mandatory Sinking Account Payment, such Bonds so purchased or deposited or redeemed shall be applied, to the extent of the full principal amount thereof, to reduce said Mandatory Sinking Account Payment. All Bonds purchased or deposited pursuant to this subsection shall be delivered to the Bond Trustee and canceled. All Bonds purchased from the Sinking Account or deposited by the Corporation with the Bond Trustee shall be allocated first to the next succeeding Mandatory Sinking Account Payment, then to the remaining Mandatory Sinking Account Payments as the Corporation directs. Subject to the terms and conditions set forth in the Bond Indenture, the Bonds shall be redeemed (or paid at maturity, as the case may be) by application of Mandatory Sinking Account Payments as described in the Bond Indenture.

Upon the receipt thereof, the Bond Trustee shall deposit the following amounts in a special fund designated the "Redemption Fund" which the Bond Trustee shall establish and maintain and hold in trust:

(a) all moneys deposited by the Corporation or the Members with the Bond Trustee directed to be deposited in the Redemption Fund; and

(b) all interest, profits and other income received from the investment of moneys in the Redemption Fund.

All amounts deposited in the Redemption Fund shall be used and withdrawn by the Bond Trustee solely for the purpose of redeeming Bonds, in the manner and upon the terms and conditions specified in the Bond Indenture, at the next succeeding date of redemption for which notice has been given, provided that at any time prior to the selection of Bonds for such redemption, the Bond Trustee shall, upon direction of the Corporation, apply such amounts to the purchase of Bonds at public or private sale, as and when and at such prices (including brokerage and other charges, but excluding accrued interest, which is payable from the Interest Account) as the Corporation may direct, except that the purchase price (exclusive of accrued interest) may not exceed the redemption price or the Make-Whole Redemption Price then applicable to such Bonds (or, if such Bonds are not then subject to redemption, the par value of such Bonds); and provided further that in lieu of redemption at such next succeeding date of redemption, or in combination therewith, amounts in such account may be transferred to the Principal Account as set forth in a Request of the Corporation.

On each Payment Date, until the principal of and interest on the Bonds shall have been fully paid or provision for such payment shall have been made as provided in the Bond Indenture, the Corporation shall pay to the Bond Trustee a sum equal to the amount payable on such Payment Date as principal of and interest on the Bonds. Such payments shall be made in federal funds or other funds immediately available at the Corporate Trust Office of the Bond Trustee and shall be promptly deposited by the Bond Trustee upon receipt thereof in the Bond Fund. Each payment shall at all times be sufficient to pay the total amount of interest and principal (whether at maturity or upon acceleration) becoming due and payable on the Bonds on such Payment Date. If on any Payment Date the amounts held by the Bond Trustee in the accounts within the Bond Fund are insufficient to make any required payments of principal of (whether at maturity or upon acceleration) and interest on the Bonds as such payments become due, the Corporation shall forthwith pay such deficiency to the Bond Trustee.

The obligations of the Corporation to make the payments required by the Bond Indenture and to perform and observe the other agreements on its part contained in the Bond Indenture shall be a general obligation of the Corporation, absolute and unconditional, irrespective of any defense or any rights of set-off, recoupment or counterclaim it might otherwise have against the Bond Trustee, and during the term of the Bond Indenture, the Corporation shall pay all payments required to be made under the Bond Indenture (which payments shall be net of any other obligations of the Corporation) as prescribed therein and all other payments required under the Bond Indenture, free of any deductions and without abatement, diminution or set-off. Until such time as the principal of and interest on the Bonds shall have been fully paid, or provision for the payment thereof shall have been made as required by the Bond Indenture, the Corporation (i) will not suspend or discontinue any payments provided for in (A) hereof; (ii) will perform and observe all of its other covenants contained in the Bond Indenture; and (iii) except as provided in Article X of the Bond Indenture, will not terminate the Bond Indenture for any cause, including, without limitation, the occurrence of any act or circumstances that may constitute failure of consideration, destruction of or damage to all or a portion of the projects financed with the proceeds of the Bonds, commercial frustration of purpose, any change in the tax or other laws of the United States of America or of the State of Minnesota or any political subdivision of either of these, or any failure of the Bond Trustee to perform and observe any covenant, whether express or implied, or any duty, liability or obligation arising out of or connected with the Bond Indenture, except to the extent permitted by the Bond Indenture.

All moneys in any of the funds and accounts established pursuant to the Bond Indenture shall be invested and reinvested by the Bond Trustee, upon written direction of the Corporation, solely in such investment securities as may be specified in writing by the Corporation. The Bond Trustee shall acquire such investment securities upon the written direction of the Corporation at such prices and on such terms as directed by the Corporation.

Unless otherwise specifically provided in the Bond Indenture, all interest, profits and other income received from the investment of moneys in any fund or account established pursuant to the Bond Indenture shall be deposited when received in such fund or account. Notwithstanding anything to the contrary contained in this paragraph, an amount of interest received with respect to any investment security equal to the amount of accrued interest, if any, paid as part of the purchase price of such investment security shall be credited to the fund or account for the credit of which such investment security was acquired. Investment securities acquired as an investment of moneys in any fund or account established under the Bond Indenture shall be credited to such fund or account.

Replacement of the Series 2015 Obligation with an Obligation Issued Under a Separate Master Indenture

The Series 2015 Obligation shall be surrendered by the Bond Trustee and delivered to the Master Trustee for cancellation upon receipt by the Bond Trustee of the following:

(1) a Request of the Corporation requesting such surrender and delivery and stating that the Corporation has become a member of an obligated group under a master indenture (other than the Master Indenture) (or an entity which, directly or indirectly, controls the Corporation has become a member of such an obligated group and the Corporation is obligated, by its articles of incorporation, bylaws or by contract or otherwise, to make payments to such controlling entity in amounts sufficient to enable the entity to make payments with respect to obligations issued under such master indenture) and that an obligation is being issued to the Bond Trustee under such replacement master indenture (the "Replacement Master Indenture");

(2) a properly executed obligation (the "Replacement Obligation") issued under the Replacement Master Indenture and registered in the name of the Bond Trustee with the same tenor and effect as the Series 2015 Obligation (in a principal amount equal to then Outstanding principal amount of Bonds), duly authenticated by the master trustee under the Replacement Master Indenture;

(3) an Opinion of Counsel selected by the Corporation and not objected to by the Bond Trustee to the effect that the Replacement Obligation has been validly issued under the Replacement Master Indenture and constitutes a valid and binding obligation of the Corporation (or the entity which directly or indirectly controls the Corporation, if applicable) and each other Obligated Group Member (if any) which is jointly and severally liable under the Replacement Master Indenture, subject to such qualifications as are acceptable to the Bond Trustee;

(4) a copy of the Replacement Master Indenture, certified as a true and accurate copy by the master trustee under the Replacement Master Indenture; and

(5) written confirmation from each rating agency then rating the Bonds that the replacement of the Series 2015 Obligation will not, by itself, result in a reduction in then-current ratings on the Bonds; and

Upon satisfaction of such conditions, all references in the Bond Indenture to the Series 2015 Obligation shall be deemed to be references to the Replacement Obligation, all references to the Master Indenture shall be deemed to be references to the Replacement Master Indenture, all references to the Master Trustee shall be deemed to be references to the master trustee under the Replacement Master Indenture, all references to the Obligated Group and the Obligated Group Members shall be deemed to be references to the obligated group and the obligated group members under the Replacement Master Indenture and all references to Supplemental Master Indenture for the Series 2015 Obligation shall be deemed to be references to the supplemental master indenture pursuant to which the Replacement Obligation is issued.

Events of Default and Remedies

The following events are Events of Default under the Bond Indenture:

(a) default in the due and punctual payment of the principal or redemption price, including the Make-Whole Redemption Price, if any, of any Bond when and as the same shall become due and payable, whether at maturity as therein expressed, by proceedings for redemption, by acceleration or otherwise;

(b) default in the due and punctual payment of any installment of interest on any Bond when and as such interest installment shall become due and payable;

(c) if the Corporation shall fail to observe or perform any covenant, condition, agreement or provision in the Bond Indenture on its part to be observed or performed, other than as referred to in subsection (a) - (b) above, or shall breach any warranty by the Corporation contained in the Bond Indenture, for a period of sixty (60) days after written notice, specifying such failure or breach and requesting that it be remedied, has been given to the Corporation by the Bond Trustee; except that, if such failure or breach can be remedied but not within such sixty-day period and if the Corporation has taken all action reasonably possible to remedy such failure or breach within such sixty-day period, such failure or breach shall not become an Event of Default for so long as the Corporation shall diligently proceed to remedy the same in accordance with and subject to any directions or limitations of time established by the Bond Trustee;

(d) if the Corporation files a petition in voluntary bankruptcy, for the composition of its affairs or for its corporate reorganization under any state or federal bankruptcy or insolvency law, or makes an assignment for the benefit of creditors, or admits in writing to its insolvency or inability to pay debts as they mature, or consents in writing to the appointment of a trustee or receiver for itself or for the whole or any substantial part of the Corporation's facilities;

(e) if a court of competent jurisdiction shall enter an order, judgment or decree declaring the Corporation an insolvent, or adjudging it bankrupt, or appointing a trustee or receiver of the Corporation or of the whole or any substantial part of the Corporation's facilities, or approving a petition filed against the Corporation seeking reorganization of the Corporation under any applicable law or statute of the United States of America or any state thereof, and such order, judgment or decree shall not be vacated or set aside or stayed within sixty (60) days from the date of the entry thereof;

(f) if, under the provisions of any other law for the relief or aid of debtors, any court of competent jurisdiction shall assume custody or control of the Corporation's facilities, and such custody or control shall not be terminated within sixty (60) days from the date of assumption of such custody or control; and

(g) an Event of Default under and as defined in the Master Indenture.

Upon actual knowledge of the existence of any Event of Default, the Bond Trustee shall notify the Corporation and the Master Trustee in writing as soon as practicable; provided, however, that the Bond Trustee need not provide notice of any Event of Default if the Corporation has expressly acknowledged the existence of such Event of Default in a writing delivered to the Bond Trustee and the Master Trustee.

Acceleration of Maturities

Whenever any Event of Default shall have happened and be continuing under the Bond Indenture, the Bond Trustee may, and shall at the written direction of the Holders of a majority in principal amount of the Bonds then Outstanding, notify the Master Trustee of such Event of Default, may make a demand for payment under the Series 2015 Obligation and request the Master Trustee in writing to give notice to the Members pursuant to the Master Indenture declaring the principal of all Obligations issued under the Master Indenture then outstanding to be due and immediately payable. Upon such declaration by the Master Trustee, the Bond Trustee shall declare the principal of all the Bonds then Outstanding, and the interest accrued thereon, to be due and payable immediately, and upon any such declaration the same shall become and shall be immediately due and payable, anything in the Bond Indenture

to the contrary notwithstanding. In addition, the Bond Trustee may take whatever action at law or in equity is necessary or desirable to collect the payments due under the Series 2015 Obligation.

Any such declaration, however, is subject to the condition that if, at any time after such declaration and before any judgment or decree for the payment of the moneys due shall have been obtained or entered, the Corporation shall deposit with the Bond Trustee a sum sufficient to pay all the principal or redemption price of and installments of interest on the Bonds, payment of which is overdue, with interest on such overdue principal at the rate borne by the respective Bonds, and the reasonable charges and expenses of the Bond Trustee (including fees and expenses of its attorneys), and if the Bond Trustee has received notification from the Master Trustee that the declaration of acceleration of the Series 2015 Obligation has been annulled pursuant to the Master Indenture, and any and all other defaults known to the Bond Trustee (other than in the payment of principal of and interest on the Bonds due and payable solely by reason of such declaration) shall have been made good or cured to the satisfaction of the Bond Trustee or provision deemed by the Bond Trustee to be adequate shall have been made therefor, then, and in every such case, the Bond Trustee shall, on behalf of the Holders of all of the Bonds, rescind and annul such declaration of acceleration of the Bonds and its consequences and waive such default; but no such rescission and annulment shall extend to or shall affect any subsequent default, or shall impair or exhaust any right or power consequent thereon.

Immediately after any acceleration under the Bond Indenture, the Bond Trustee, to the extent it has not already done so, shall notify in writing the Corporation of the occurrence of such acceleration.

Application of Funds after Default

If an Event of Default shall occur and be continuing under the Bond Indenture, all moneys then held or thereafter received by the Bond Trustee under any of the provisions of the Bond Indenture shall be applied by the Bond Trustee as follows and in the following order: (a) To the payment of any expenses necessary in the opinion of the Bond Trustee to protect the interests of the Holders of the Bonds and payment of reasonable charges and expenses of the Bond Trustee (including reasonable fees and disbursements of its counsel) incurred in and about the performance of its powers and duties under the Bond Indenture; and (b) To the payment of the principal or redemption price, including the Make-Whole Redemption Price, if any, of and interest then due on the Bonds (upon presentation of the Bonds to be paid, and stamping thereon of the payment if only partially paid, or surrender thereof if fully paid) subject to the provisions of the Bond Indenture, as follows:

(i) Unless the principal of all of the Bonds shall have become or have been declared due and payable,

First: To the payment to the Persons entitled thereto of all installments of interest then due in the order of the maturity of such installments, and, if the amount available shall not be sufficient to pay in full any installment or installments maturing on the same date, then to the payment thereof ratably, according to the amounts due thereon, to the Persons entitled thereto, without any discrimination or preference; and

Second: To the payment to the Persons entitled thereto of the unpaid principal or redemption price, including the Make-Whole Redemption Price, if any, of any Bonds which shall have become due, whether at maturity or by call for redemption, in the order of their due dates, with interest on the overdue principal at the rate borne by the respective Bonds, and, if the amount available shall not be sufficient to pay in full all the Bonds due on any date, together with such interest, then to the payment thereof ratably, according to the amounts of principal or redemption price, including the Make-Whole Redemption Price, if any, due on such date to the Persons entitled thereto, without any discrimination or preference.

(ii) If the principal of all of the Bonds shall have become or have been declared due and payable, to the payment of the principal and interest then due and unpaid upon the Bonds, with interest on the overdue principal at the rate borne by the respective Bonds, and, if the amount available shall not be sufficient to pay in full the whole amount so due and unpaid, then to the payment thereof ratably, without preference or priority of principal over interest, or of interest over principal, or of any installment of interest over any other installment of interest, or of any Bond over any other Bond, according to the amounts due respectively for principal and interest, to the Persons entitled thereto without any discrimination or preference.

Bond Trustee to Represent Bondholders

The Bond Trustee is irrevocably appointed by the Bond Indenture (and the successive respective Holders of the Bonds, by taking and holding the same, shall be conclusively deemed to have so appointed the Bond Trustee) as trustee and true and lawful attorney-in-fact of the Holders of the Bonds for the purpose of exercising and prosecuting on their behalf such rights and remedies as may be available to such Holders under the provisions of the Bonds, the Bond Indenture, the Series 2015 Obligation and applicable provisions of any law. Upon the occurrence and continuance of an Event of Default or other occasion giving rise to a right in the Bond Trustee to represent the Bondholders, the Bond Trustee in its discretion may, and upon the written request of the Holders of not less than twenty-five percent (25%) in aggregate principal amount of the Bonds then Outstanding and upon being indemnified to its satisfaction therefor, shall, proceed to protect or enforce its rights or the rights of such Holders by such appropriate action, suit, mandamus or other proceedings as it shall deem most effectual to protect and enforce any such right, at law or in equity, either for the specific performance of any covenant or agreement contained in the Bond Indenture, or in aid of the execution of any power granted in the Bond Indenture, or for the enforcement of any other appropriate legal or equitable right or remedy vested in the Bond Trustee or in such Holders under the Bond Indenture, the Series 2015 Obligation or any law; and upon instituting such proceeding, the Bond Trustee shall be entitled, as a matter of right, to the appointment of a receiver of the amounts and assets pledged under the Bond Indenture, pending such proceedings. If more than one such request is received by the Bond Trustee from the Holders, the Bond Trustee shall follow the written request executed by the Holders of the greater percentage of Bonds then Outstanding in excess of twenty-five percent (25%). All rights of action under the Bond Indenture or the Bonds or otherwise may be prosecuted and enforced by the Bond Trustee without the possession of any of the Bonds or the production thereof in any proceeding relating thereto, and any such suit, action or proceeding instituted by the Bond Trustee shall be brought in the name of the Bond Trustee for the benefit and protection of all the Holders of the Bonds, subject to the provisions of the Bond Indenture.

Bondholders' Direction of Proceedings

The Holders of a majority in aggregate principal amount of the Bonds then Outstanding, shall have the right, by an instrument or concurrent instruments in writing executed and delivered to the Bond Trustee, to direct the method of conducting all remedial proceedings taken by the Bond Trustee under the Bond Indenture, provided that such direction shall not be otherwise than in accordance with law and the provisions of the Bond Indenture, and that the Bond Trustee shall have the right to decline to follow any such direction which in the opinion of the Bond Trustee would be unjustly prejudicial to Bondholders not parties to such direction

Limitation on Bondholders' Right to Sue

No Holder of any Bond shall have the right to institute any suit, action or proceeding at law or in equity, for the protection or enforcement of any right or remedy under the Bond Indenture, the Series 2015 Obligation or any applicable law with respect to such Bond, unless (a) such Holder shall have given to the Bond Trustee written notice of the occurrence of an Event of Default; (b) the Holders of not less than twenty-five percent (25%) in aggregate principal amount of the Bonds then Outstanding shall have made written request upon the Bond Trustee to exercise the powers granted or to institute such suit, action or proceeding in its own name; provided, however, that if more than one such request is received by the Bond Trustee from the Holders, the Bond Trustee shall follow the written request executed by the Holders of the greater percentage of Bonds then Outstanding in excess of twenty-five percent (25%); (c) such Holder or said Holders shall have tendered to the Bond Trustee reasonable indemnity against the costs, expenses and liabilities to be incurred in compliance with such request; and (d) the Bond Trustee shall have refused or omitted to comply with such request for a period of sixty (60) days after such written request shall have been received by, and said tender of indemnity shall have been made to, the Bond Trustee.

Such notification, request, tender of indemnity and refusal or omission are declared, in every case, to be conditions precedent to the exercise by any Holder of Bonds of any remedy under the Bond Indenture or under law; it being understood and intended that no one or more Holders of Bonds shall have any right in any manner whatever by such Holder's or Holders' action to affect, disturb or prejudice the security of the Bond Indenture or the rights of any other Holders of Bonds, or to enforce any right under the Bond Indenture, the Series 2015 Obligation or applicable law with respect to the Bonds, except in the manner in the Bond Indenture provided, and that all proceedings at law or in equity to enforce any such right shall be instituted, had and maintained in the manner in the

Bond Indenture provided and for the benefit and protection of all Holders of the Outstanding Bonds, subject to the provisions of the Bond Indenture.

Absolute Obligation of Corporation

Nothing in the Bond Indenture, or in the Bonds, contained shall affect or impair the obligation of the Corporation, which is absolute and unconditional, to pay the principal or redemption price, including the Make-Whole Redemption Price, if any, of and interest on the Bonds to the respective Holders of the Bonds at their respective dates of maturity, or upon call for redemption, as provided in the Bond Indenture, or affect or impair the right of such Holders, which is also absolute and unconditional, to enforce such payment by virtue of the contract embodied in the Bonds.

Modification or Amendment of the Bond Indenture; Amendments Permitted

The Bond Indenture and the rights and obligations of the Corporation and of the Holders of the Bonds and of the Bond Trustee may be modified or amended from time to time and at any time by a Supplemental Bond Indenture, which the Corporation and the Bond Trustee may enter when the written consent of the Holders of a majority in aggregate principal amount of the Bonds then Outstanding, shall have been filed with the Bond Trustee. No such modification or amendment shall (1) extend the stated maturity of any Bond, or reduce the amount of principal thereof, or extend the time of payment or change the rate of interest thereon, or extend the time of payment of interest thereon, or reduce any premium payable upon the redemption thereof, without the consent of the Holder of each Bond so affected, or (2) reduce the aforesaid percentage of Bonds, the consent of the Holders of which is required to effect any such modification or amendment, or permit the creation of any lien on the assets pledged under the Bond Indenture prior to or on a parity with the lien created by the Bond Indenture, or deprive the Holders of the Bonds of the lien created by the Bond Indenture on such assets (except as expressly provided in the Bond Indenture), without the consent of the Holders of all Bonds then Outstanding. It shall not be necessary for the consent of the Bondholders to approve the particular form of any Supplemental Bond Indenture, but it shall be sufficient if such consent shall approve the substance thereof. Promptly after the execution by the Corporation and the Bond Trustee of any Supplemental Bond Indenture pursuant to this subsection (A), the Bond Trustee shall mail a notice, setting forth in general terms the substance of such Supplemental Bond Indenture to the Bondholders at the addresses shown on the registration books maintained by the Bond Trustee. Any failure to give such notice, or any defect therein, shall not, however, in any way impair or affect the validity of any such Supplemental Bond Indenture.

The Bond Indenture and the rights and obligations of the Corporation, of the Bond Trustee and of the Holders of the Bonds may also be modified or amended from time to time and at any time by a Supplemental Bond Indenture, which the Corporation and the Bond Trustee may enter into without the necessity of obtaining the consent of any Bondholders, but only to the extent permitted by law and only for any one or more of the following purposes:

(1) to add to the covenants and agreements of the Corporation contained in the Bond Indenture other covenants and agreements thereafter to be observed, to pledge or assign additional security for the Bonds (or any portion thereof), or to surrender any right or power reserved to or conferred upon the Corporation in the Bond Indenture, provided, that no such covenant, agreement, pledge, assignment or surrender shall materially adversely affect the interests of the Holders of the Bonds;

(2) to make such provisions for the purpose of curing any ambiguity, inconsistency or omission, or of curing or correcting any defective provision, contained in the Bond Indenture, or in regard to matters or questions arising under the Bond Indenture, as the Corporation or the Bond Trustee may deem necessary or desirable and not inconsistent with the Bond Indenture, and which shall not materially adversely affect the interests of the Holders of the Bonds;

(3) to modify, amend or supplement the Bond Indenture in such manner as to permit the qualification hereof under the Trust Indenture Act of 1939, as amended, or any similar federal statute hereafter in effect, and to add such other terms, conditions and provisions as may be permitted by said act or similar federal statute, and which shall not materially adversely affect the interests of the Holders of the Bonds;

(4) to facilitate (i) the transfer of Bonds from one Securities Depository to another in the succession of Securities Depositories, or (ii) the withdrawal from a Securities Depository of Bonds held in a Book-Entry System and the issuance of replacement Bonds in fully registered form to Persons other than a Securities Depository;

(5) to make any changes required by a Rating Agency in order to obtain or maintain a rating for the Bonds;

(6) to provide for the issuance of Additional Bonds; or

(7) to make any other changes which will not materially adversely affect the interests of the Holders of the Bonds.

The Bond Trustee may in its discretion, but shall not be obligated to, enter into any such Supplemental Bond Indenture authorized by subsections (A) or (B) of this Section which materially adversely affects the Bond Trustee's own rights, duties or immunities under the Bond Indenture or otherwise. In executing, or accepting the additional trusts created by, any Supplemental Bond Indenture permitted by this Article or the modifications thereby of the trusts created by the Bond Indenture, the Bond Trustee shall be entitled to receive, and shall be fully protected in relying upon, an Opinion of Counsel stating that the execution of such Supplemental Bond Indenture is authorized by and in compliance with the Bond Indenture.

Defeasance

The Bonds may be paid by the Corporation or the Bond Trustee on behalf of the Corporation in any of the following ways: (a) (A) by paying or causing to be paid the principal or redemption price, including the Make-Whole Redemption Price, if any, of and interest on all Bonds Outstanding, as and when the same become due and payable; (b) by depositing with the Bond Trustee, in trust, at or before maturity, moneys or securities in the necessary amount (as provided in the Bond Indenture) to pay when due or redeem all Bonds then Outstanding; or (c) by delivering to the Bond Trustee, for cancellation by it, all Bonds then Outstanding.

If the Corporation shall pay all Bonds Outstanding and shall also pay or cause to be paid all other sums payable under the Bond Indenture by the Corporation, then and in that case at the election of the Corporation (evidenced by a Certificate of the Corporation filed with the Bond Trustee signifying the intention of the Corporation to discharge all such indebtedness and the Bond Indenture), and notwithstanding that any Bonds shall not have been surrendered for payment, the Bond Indenture and the pledge of assets made under the Bond Indenture and all covenants, agreements and other obligations of the Corporation under the Bond Indenture (except as otherwise specifically provided in the Bond Indenture) shall cease, terminate, become void and be completely discharged and satisfied. In such event, upon the request of the Corporation, the Bond Trustee shall cause an accounting for such period or periods as may be requested by the Corporation to be prepared and filed with the Corporation and shall execute and deliver all such instruments as may be necessary to evidence such discharge and satisfaction, and the Bond Trustee shall pay over, transfer, assign or deliver to the Corporation, all moneys or securities or other property held by it pursuant to the Bond Indenture which are not required for the payment or redemption of Bonds not theretofore surrendered for such payment or redemption.

Upon the deposit with the Bond Trustee, in trust, at or before maturity, of moneys or securities in the necessary amount (as provided in the Bond Indenture) to pay or redeem any Outstanding Bond (whether upon or prior to its maturity or the redemption date of such Bond), provided that, if such Bond is to be redeemed prior to maturity, notice of such redemption shall have been given as provided in the Bond Indenture or provision satisfactory to the Bond Trustee shall have been made for the giving of such notice, then all liability of the Corporation in respect of such Bond shall cease, terminate, become void and be completely discharged and satisfied, except only that thereafter the Holder thereof shall be entitled to payment of the principal of and interest on such Bond by the Corporation, and the Corporation shall remain liable for such payments, but only out of such money or securities deposited with the Bond Trustee as aforesaid for their payment, subject, however, to the provisions of the Bond Indenture.

The Corporation may at any time surrender to the Bond Trustee for cancellation by it any Bonds previously issued and delivered, which the Corporation may have acquired in any manner whatsoever, and such Bonds, upon such surrender and cancellation, shall be deemed to be paid and retired.

Deposit of Money or Securities with Bond Trustee

Whenever in the Bond Indenture it is provided or permitted that there be deposited with or held in trust by the Bond Trustee money or securities in the necessary amount to pay or redeem any Bonds, the money or securities to be so deposited or held may include money or securities held by the Bond Trustee in the funds and accounts established pursuant to the Bond Indenture and shall be: (a) lawful money of the United States of America in an amount equal to the principal amount of the Bonds and all unpaid interest thereon to maturity, except that, in the case of Bonds which are to be redeemed prior to maturity and in respect of which notice of such redemption shall have been given or provision satisfactory to the Bond Trustee shall have been made for the giving of such notice, the amount to be deposited or held shall be the principal amount or redemption price, including the Make-Whole Redemption Price, if any, of the Bonds and all unpaid interest thereon to the redemption date; or (b) United States Government Obligations (not callable by the Corporation thereof prior to maturity), the principal of and interest on which when due (without any income from the reinvestment thereof) will provide money sufficient to pay the principal or redemption price, including the Make-Whole Redemption Price, if any, of and all unpaid interest to maturity, or to the redemption date, as the case may be, on the Bonds to be paid or redeemed, as such principal or redemption price, including the Make-Whole Redemption Price, if any, and interest become due; provided that, in the case of Bonds which are to be redeemed prior to the maturity thereof, notice of such redemption shall have been given as in Article IV provided or provision satisfactory to the Bond Trustee shall have been made for the giving of such notice; provided, in each case, that the Bond Trustee shall have been irrevocably instructed (by the terms of the Bond Indenture or by Request of the Corporation) to apply such money to the payment of such principal or redemption price, including the Make-Whole Redemption Price, if any, and interest with respect to such Bond.

APPENDIX D

FORM OF CONTINUING DISCLOSURE UNDERTAKING

This Continuing Disclosure Undertaking (the "Disclosure Undertaking") is executed and delivered by Allina Health System ("Allina Health"), as Obligated Group Agent, in connection with the issuance of $250,000,000 Allina Health System Taxable Bonds, Series 2015 (the "Bonds"). The Bonds are being issued pursuant to a Bond Indenture, dated as of September 1, 2015 (the "Bond Indenture"), between Allina Health and Wells Fargo Bank, National Association, as bond trustee (the "Bond Trustee"). The payments due from Allina Health under the Bond Indenture are secured by Allina Health System Direct Note Obligation, Series 2015 (the "Series 2015 Obligation") issued under a Master Trust Indenture, dated as of October 1, 1998 (as supplemented and amended to date, the "Master Indenture"), between Allina Health, as Obligated Group Agent, and Wells Fargo Bank, National Association, as master trustee (the "Master Trustee"), including as supplemented by the Twentieth Supplemental Master Indenture. Allina Health hereby covenants and agrees as follows:

SECTION 1. Purpose of the Disclosure Undertaking. This Disclosure Undertaking is being executed and delivered by Allina Health, as Obligated Group Agent, for the benefit of the Holders and Beneficial Owners (defined below) of the Bonds.

SECTION 2. Definitions. In addition to the definitions set forth above and in the Bond Indenture and the Master Indenture, which, as applicable, apply to any capitalized term used in this Disclosure Undertaking unless otherwise defined in this Disclosure Undertaking, the following capitalized terms shall have the following meanings:

"Annual Report" shall mean any Annual Report provided by Allina Health pursuant to, and as described in, Sections 3 and 4 of this Disclosure Undertaking.

"Audited Financial Statements" shall mean the audited financial statements required to be delivered to the Master Trustee pursuant to Section 406 of the Master Indenture.

"Beneficial Owner" shall mean any Person which has or shares the power, directly or indirectly, to make investment decisions concerning ownership of any Bonds (including Persons holding Bonds through nominees, depositories or other intermediaries).

"Dissemination Agent" shall mean an agent of Allina Health that may be appointed by Allina Health from time to time to disseminate the reports and information required pursuant to this Disclosure Undertaking, or any successor Dissemination Agent designated in writing by Allina Health, and which has filed with Allina Health a written acceptance of such designation.

"Listed Events" shall mean any of the events listed in Section 5(a) of this Disclosure Undertaking.

"MSRB" shall mean the Municipal Securities Rulemaking Board or any other entity designated or authorized by the SEC to receive reports or notices pursuant to the Rule.

"Obligated Person" shall mean Allina Health and any future Credit Group Member, to the extent such Credit Group Member constitutes an "obligated person" as defined in the Rule.

"Offering Memorandum" shall mean the Offering Memorandum, dated September 9, 2015, related to the Bonds.

"Participating Underwriters" shall mean, the original underwriters of the Bonds.

"Repository" shall mean (i) for so long as Allina Health has tax-exempt obligations outstanding, the MSRB, and (2) thereafter, another nationally recognized disclosure site selected by Allina Health or through a website maintained by Allina Health.

"Rule" shall mean Rule 15c2-12(b)(5) adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as the same may be amended from time to time.

SECTION 3. Provision of Quarterly and Annual Reports.

(a) Allina Health shall, or shall cause the Dissemination Agent to, not later than 150 days after the end of Allina Health's fiscal year, commencing with the fiscal year ending December 31, 2015, provide to the Repository an Annual Report which is consistent with the requirements of Section 4 of this Disclosure Undertaking. In each case, the Annual Report may cross-reference other information as provided in Section 4 of this Disclosure Undertaking; provided that the Audited Financial Statements may be submitted separately from the balance of the Annual Report and later than the date required above for the filing of the Annual Report if they are not available by that date. If Allina Health's or any future Credit Group Member's fiscal year changes, it shall give, or shall cause to be given, notice of such change in the same manner as for a Listed Event under Section 5.

(b) Allina Health shall provide the Annual Report to any Dissemination Agent (if any) prior to the date for filing of the Annual Report specified in Section 3(a). If Allina Health is unable to provide to the Repository an Annual Report by the date required in Section 3(a), Allina Health shall, in a timely manner, send a notice to the Repository in substantially the form attached as Exhibit A

(c) In addition to the Annual Report required to be filed pursuant to Section 3(a), Allina Health shall, or shall cause the Dissemination Agent to, provide to the Repository (1) not later than 45 days after the end of each quarter of the Credit Group's fiscal year, beginning with the fiscal quarter ending September 30, 2015, unaudited financial information for the Credit Group (which may be part of consolidated financial statements for a larger group of affiliated organizations), for such fiscal quarter, including a balance sheet, a cash flow statement and a statement of operations, and (2) not later than 150 days after the end of the Credit Group's fiscal year, beginning with 2015, the Annual Report.

(d) The Dissemination Agent, shall have no duty or obligation to review an Annual Report or any quarterly financial information to verify the content or correctness of an Annual Report or quarterly financial information.

(e) Until otherwise designated by the MSRB or the SEC, filings with the MSRB are to be made through the Electronic Municipal Market Access (EMMA) website of the MSRB, currently located at http://emma.msrb.org.

SECTION 4. Content of Annual Reports. The Annual Report shall contain or include by reference the following:

1. The Audited Financial Statements for the prior fiscal year, prepared in accordance with generally accepted accounting principles as promulgated from time to time by the Financial Accounting Standards Board. If the Audited Financial Statements are not available by the time the Annual Report is required to be filed pursuant to Section 3(a), the Annual Report shall contain unaudited financial statements in a format similar to the financial statements contained in the final Offering Memorandum, and the audited consolidated financial statements shall be filed in the same manner as the Annual Report when they become available.

2. An update of the following information substantially similar in type and scope, to the extent not included in the Audited Financial Statements:

(a) The list of current Credit Group Members as of the end of the most recently completed fiscal year;

(b) The information contained in the table in Appendix A to the Offering Memorandum under the heading "FACILITIES AND OPERATIONS – Hospitals" for the most recently completed fiscal year;

(c) The information contained in the table in Appendix A to the Offering Memorandum under the heading "STATISTICAL INFORMATION – Consolidated Utilization Table" for the most recently completed fiscal year;

(d) The number of clinics and employed physicians for the most recently completed fiscal year;

(e) The information contained in the table in Appendix A to the Offering Memorandum under the heading "FINANCIAL INFORMATION – Managed Care Relationships" for the most recently completed fiscal year;

(f) The calculation of the capitalization for the most recently completed fiscal year;

(g) The calculation of historical annual debt service coverage ratio and historical maximum annual debt service coverage ratio for the most recently completed fiscal year;

(h) The information contained in Appendix A to the Offering Memorandum under the heading "INVESTMENT MANAGEMENT – Investment Pools" for the most recently completed fiscal year;

(i) The calculation of days cash on hand for the most recently completed fiscal year;

(j) The information contained in Appendix A to the Offering Memorandum under the heading "INVESTMENT MANAGEMENT – Debt and Swap Structure" for the most recently completed fiscal year; and

(k) The information contained in Appendix A to the Offering Memorandum under the heading "EMPLOYEE RETIREMENT PLANS" for the most recently completed fiscal year.

Any or all of the items listed in Section 2(a)-(k) above may be included by specific reference to other documents, including official statements of debt issues with respect to which Allina Health or any other Credit Group Members are an "obligated person" (as defined by the Rule), which have been filed with the MSRB. If the document included by reference is a final official statement, it must be available from the MSRB. Allina Health shall clearly identify each such other document so included by reference.

SECTION 5. Reporting of Significant Events.

(a) Allina Health shall give, or cause to be given, notice of the occurrence of any of the following events with respect to the Bonds:

1. principal and interest payment delinquencies;

2. nonpayment related defaults, if material;

3. unscheduled draws on debt service reserves reflecting financial difficulties;

4. unscheduled draws on credit enhancements reflecting financial difficulties;

5. substitution of credit or liquidity provider or its failure to perform;

6. modifications to rights of Bondholders, if material;

7. bond calls, if material, and tender offers;

8. defeasances;

9. release, substitution or sale of property securing repayment of the Bonds, if material;

10. rating changes;

11. bankruptcy, insolvency, receivership, or similar event of an Obligated Person;

12. the consummation of a merger, consolidation or acquisition involving an Obligated Person or the sale of all or substantially all the assets of an Obligated Person, other than in the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and

13. the appointment of a successor or additional trustee, or the change in the name of the Bond Trustee, if material.

Note: for the purposes of the event identified in subparagraph (11), the event is considered to occur when any of the following occur: the appointment of a receiver, fiscal agent or similar officer for an obligated person in a proceeding under the U.S. Bankruptcy Code or in any other proceeding under state or federal law in which a court or governmental authority has assumed jurisdiction over substantially all of the assets or business of the obligated person, or if such jurisdiction has been assumed by leaving the existing governmental body and officials or officers in possession but subject to the supervision and orders of a court or governmental authority, or the entry of an order confirming a plan of reorganization, arrangement or liquidation by a court or governmental authority having supervision or jurisdiction over substantially all of the assets or business of the obligated person;

(b) Allina Health shall file, or cause to be filed, notice of the occurrence of a Listed Event with the Repository, in a timely manner but not in excess of 10 Business Days after the occurrence of such Listed Event. Reference is hereby made to the Rule for a discussion of when certain events enumerated in this Section 5 are deemed to have "occurred." Until otherwise designated by the MSRB or the SEC, filings with the MSRB are to be made through the Electronic Municipal Market Access (EMMA) website of the MSRB, currently located at http://emma.msrb.org.

SECTION 6. Termination of Reporting Obligation. Allina Health's obligations under this Disclosure Undertaking shall terminate upon the legal defeasance, prior redemption or payment in full of all of the Bonds. If Allina Health's obligations under this Disclosure Undertaking are assumed in full by some other entity, such Person shall be responsible for compliance with this Disclosure Undertaking in the same manner as if it were Allina Health and Allina Health shall have no further responsibility hereunder. If such termination or substitution occurs prior to the final maturity of the Bonds, Allina Health shall give, or cause to be given, notice of such termination or substitution in the same manner as for a Listed Event under Section 5.

SECTION 7. Dissemination Agent. Allina Health may, from time to time, appoint or engage a Dissemination Agent to assist it in carrying out its obligations under this Disclosure Undertaking, and may discharge any such Dissemination Agent, with or without appointing a successor Dissemination Agent. The Dissemination Agent shall not be responsible in any manner for the content of any notice or report provided by Allina Health pursuant to this Disclosure Undertaking. The Dissemination Agent (if other than Allina Health) may resign by providing thirty (30) days written notice to Allina Health. The Dissemination Agent shall have no duty to prepare any information report nor shall the Dissemination Agent be responsible for filing any report not provided to it by Allina Health in a timely manner and in a form suitable for filing. If at any time there is not any other designated Dissemination Agent, Allina Health shall be the Dissemination Agent.

SECTION 8. Amendment; Waiver. Notwithstanding any other provision of this Disclosure Undertaking, Allina Health and the Dissemination Agent, if any, may amend this Disclosure Undertaking (and the Dissemination Agent, if any, shall agree to any amendment so requested by Allina Health which does not impose any greater duties, nor greater risk of liability, on the Dissemination Agent) and any provision of this Disclosure Undertaking may be waived, provided that the following conditions are satisfied:

(a) If the amendment or waiver relates to the provisions of Sections 3(a), 4, or 5, it may only be made in connection with a change in circumstances that arises from a change in legal requirements, change in law or change in the identity, nature or status of an obligated person with respect to the Bonds or the type of business conducted (including, but not limited to, affiliations, mergers, acquisitions, divestitures or dispositions affecting the Credit Group Members); and

(c) The amendment or waiver either (i) is approved by the Holders of the Bonds in the same manner as provided in the Bond Indenture for amendments to the Bond Indenture with the consent of Holders, or (ii) does not, in the opinion of counsel expert in federal securities laws selected by Allina Health, materially impair the interests of the Holders or Beneficial Owners of the Bonds.

In the event of any amendment or waiver of a provision of this Disclosure Undertaking, Allina Health shall describe such amendment in the next Annual Report, and shall include, as applicable, a narrative explanation of the reason for the amendment or waiver and its impact on the type (or, in the case of a change of accounting principles, on the presentation) of financial information or operating data being presented by Allina Health on behalf of the Credit Group. In addition, if the amendment relates to the accounting principles to be followed in preparing financial statements, (i) Allina Health will file, or caused to be filed, notice of such change in the same manner as for a Listed Event under Section 5, and (ii) the Annual Report for the year in which the change is made should present a comparison (in narrative form and also, if feasible, in quantitative form) between the financial statements as prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles.

SECTION 9. Additional Information. Nothing in this Disclosure Undertaking shall be deemed to prevent Allina Health or any other Obligated Group Member from disseminating any other information, using the means of dissemination set forth in this Disclosure Undertaking or any other means of communication, or including any other information in any Annual Report, quarterly report or notice of occurrence of a Listed Event, in addition to that which is required by this Disclosure Undertaking. If Allina Health chooses to include any information in any Annual Report, quarterly report or notice of occurrence of a Listed Event, in addition to that which is specifically required by this Disclosure Undertaking, Allina Health shall have no obligation under this Disclosure Undertaking to update such information or include it in any future Annual Report, quarterly report or notice of occurrence of a Listed Event.

SECTION 10. Default. In the event of a failure of Allina Health or the Dissemination Agent, if any, to comply with any provision of this Disclosure Undertaking, the Bond Trustee may (and, at the request of the Participating Underwriter or the Holders of at least twenty-five percent (25%) aggregate principal amount of Outstanding Bonds to which this Disclosure Undertaking then applies, shall, but only to the extent funds in an amount satisfactory to the Bond Trustee have been provided to it or it has otherwise been indemnified to its satisfaction from any cost, liability, expense or additional charges of the Bond Trustee, including attorney's fees), or any Holder or Beneficial Owner of the Bonds may take such actions as may be necessary and appropriate, including seeking mandate or specific performance by court order, to cause Allina Health or the Dissemination Agent, if any and as the case may be, to comply with its respective obligations under this Disclosure Undertaking. A default under this Disclosure Undertaking shall not be deemed an Event of Default under the Bond Indenture or the Master Indenture and the sole remedy under this Disclosure Undertaking in the event of any failure of Allina Health or the Dissemination Agent, if any, to comply with this Disclosure Undertaking shall be an action to compel performance.

SECTION 11. Duties, Immunities and Liabilities of Dissemination Agent. The Dissemination Agent shall have only such duties as are specifically set forth in this Disclosure Undertaking, and Allina Health agrees to indemnify and save the Dissemination Agent and its respective officers, directors, employees and agents, harmless against any loss, expense and liabilities which it may incur arising out of or in the exercise or performance of its powers and duties hereunder, including the costs and expenses (including attorneys' fees) of defending against any claim of liability, but excluding liabilities due to the Dissemination Agent's own negligence or willful misconduct. The obligations of Allina Health under this Section shall survive resignation or removal of the Dissemination Agent and payment of the Bonds. Allina Health covenants that if ever it serves as Dissemination Agent, it shall take all actions required of the Dissemination Agent under this Disclosure Undertaking. The Dissemination Agent shall be paid compensation by Allina Health for its services provided hereunder as agreed by Allina Health and the Dissemination Agent and all expenses, legal fees and advances made or incurred by the Dissemination Agent in the

performance of its duties hereunder. The Dissemination Agent shall have no duty or obligation to review any information provided hereunder and is only responsible for the obligations set forth herein.

SECTION 12. Notices. Any notices or communications to Allina Health pursuant to this Disclosure Undertaking may be given as follows:

To Allina Health:

Allina Health System
2925 Chicago Ave., Mail Route 10805
Minneapolis, Minnesota 55407
Attention: Treasury Services

Allina Health may, by written notice to the Dissemination Agent, if any, designate a different address or telephone number(s) to which subsequent notices or communications should be sent.

SECTION 13. Beneficiaries. This Disclosure Undertaking shall inure solely to the benefit of Allina Health, the Dissemination Agent, if any, the Participating Underwriter, the Holders and Beneficial Owners from time to time of the Bonds, and shall create no rights in any other person or entity.

This Disclosure Undertaking may be executed in several counterparts, each of which shall be an original and all of which shall constitute but one and the same instrument.

Dated: September 16, 2015.

ALLINA HEALTH SYSTEM,
as Obligated Group Agent

By: _____
Authorized Representative

EXHIBIT A

FORM OF NOTICE TO REPOSITORY OF FAILURE TO FILE ANNUAL REPORT

Name of Issuer:	Allina Health System
Name of Bond Issue:	Allina Health System Taxable Bonds, Series 2015
Name of the Obligated Person:	Allina Health System
Date of Issuance:	September 16, 2015

NOTICE IS HEREBY GIVEN that Allina Health System ("Allina Health"), as Obligated Group Agent, has not provided an Annual Report with respect to the above-referenced bonds as required by the Continuing Disclosure Undertaking, dated the Date of Issuance of the Bonds. [Allina Health anticipates that the Annual Report will be filed by _____.]

Dated: _____

ALLINA HEALTH SYSTEM,

_____

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APPENDIX E

PRO RATA PASS-THROUGH DISTRIBUTION OF PRINCIPAL

Term Bond Due November 15, 2045

Mandatory Sinking Account Payment Date (November 15)	Mandatory Sinking Account Payment Amounts[(1)]	Paydown Amount per $1,000	Remaining Balance per $1,000	Paydown Factor	Remaining Bond Factor
Original	--	--	$1,000.00	--	1
2041	$50,000,000	$200.00	$800.00	0.200000	0.800000
2042	$50,000,000	$200.00	$600.00	0.200000	0.600000
2043	$50,000,000	$200.00	$400.00	0.200000	0.400000
2044	$50,000,000	$200.00	$200.00	0.200000	0.200000
2045	$50,000,000	$200.00	--	0.200000	0.000000

(1) Subject to change in the event of certain optional redemptions or purchases of Bonds and subject to DTC or a successor securities depository 's operational procedures on such Mandatory Sinking Account Payment date.

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