Advocate Health Care Network and Subsidiaries

QUARTERLY REPORT

For the Second Quarter Ended June 30, 2011

Advocate Health Care Network and Subsidiaries
For the Second Quarter Ended June 30, 2011

C O N T E N T S

Forward Looking Information:

This Quarterly Report contains "forward-looking statements" within the meaning of the federal securities laws. Forward-looking statements are those statements that do not relate solely to historical or current fact, and can often be identified by use of words including but not limited to like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan," or "continue." These forward-looking statements are based on the current plans and expectations of Advocate Health Care Network ("Advocate") that, although believed to be reasonable, are subject to a number of known and unknown uncertainties and risks inherent in the operation of health care facilities, many of which are beyond Advocate's control, that could significantly affect current plans and expectations and Advocate's future financial position and results of operations. These factors include, but are not limited to, the following:

- potential federal or state reform of health care, implementation of the Patient Protection and Affordable Care Act (the "Health Care Reform Act") and related rules and regulations, and any potential modifications or challenges to Health Care Reform Act or any other such legislation;
- the highly competitive nature of the health care business;
- pressures to contain costs by managed care organizations, insurers, health care providers and Advocate's ability to negotiate acceptable terms with third party payors;
- changes in the Medicare and Medicaid programs that may impact reimbursements to health care providers and insurers, as well as possible additional changes in such programs;
- Advocate's ability to attract and retain qualified management and other personnel, including affiliated physicians, nurses and medical support personnel;
- liabilities and other claims asserted against Advocate;
- changes in accounting standards and practices;
- changes in general economic conditions;
- future divestitures or acquisitions;
- changes in revenue mix or delays in receiving payments from third party payors, as has recently been the case in Illinois as a result of state budget constraints;
- the availability and cost of capital to fund future expansion plans of Advocate and to provide for ongoing capital expenditure needs;
- changes in business strategy or development plans;
- Advocate's ability to implement shared services and other initiatives and realize decreases in administrative, supply and infrastructure costs;
- the outcome of pending and any future litigation;
- the ability to achieve expected levels of patient volumes and control the costs of providing services;
- results of reviews of Advocate's cost reports; and
- increased costs from further government regulation of health care and Advocates failure to comply, or allegations of any failure to comply, with applicable laws and regulations, including without limitations laws, regulations, policies and procedures relating to Advocate's status as tax-exempt organizations as well as its ability to comply with the requirements of Medicare and Medicaid programs.

These forward-looking statements speak only as of the date made. Except as required by law, Advocate has undertaken no obligation to publicly update or revise any forward-looking statement contained in this Quarterly Report, whether as a result of in information, future events or otherwise. As a consequence, current plans, anticipated actions and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of Advocate. Investors are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this Quarterly Report.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Condensed Consolidated Balance Sheets

(dollars in thousands)

	Unaudited June 30, 2011	Note 1 December 31, 2010
Assets		
Current assets:		
Cash and cash equivalents	**$ 279,081**	**$ 542,002**
Short term investments	**12,358**	**25,464**
Assets limited as to use:		
Internally designated for self insurance programs	**71,647**	**69,604**
Patient accounts receivable		
less allowances for uncollectible accounts of $144,893 and $129,209	**415,794**	**400,855**
Amounts due from primary third-party payors	**7,524**	**4,056**
Prepaid expenses, inventories and other current assets	**224,020**	**226,943**
Collateral proceeds received under securities lending program	**18,180**	**218,777**
Total current assets	**1,028,604**	**1,487,701**
Assets limited as to use:		
Externally designated under debt agreements, net of amounts required to meet current obligations	**27,527**	**39,818**
Internally designated for capital improvement	**2,706,074**	**2,106,001**
Internally designated for self insurance programs, less current portion	**806,736**	**819,149**
Externally designated for capital improvement, medical education and health care programs	**34,799**	**33,890**
Investments under securities lending program	**18,058**	**213,830**
	3,593,194	**3,212,688**
Interests in health care and related entities	**135,119**	**132,324**
Reinsurance receivable	**175,184**	**164,074**
Deferred costs and intangible assets, less allowances for amortization	**15,168**	**15,325**
Other noncurrent assets	**111,278**	**109,766**
	4,029,943	**3,634,177**
Property and equipment -- at cost:		
Property and equipment	**3,498,784**	**3,386,043**
Less allowances for depreciation	**1,863,766**	**1,786,886**
	1,635,018	**1,599,157**
	$ 6,693,565	**$ 6,721,035**

Note 1: December 31, 2010 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2010 Audited Consolidated Financial Statements.

See accompanying notes to condensed consolidated financial statements.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Condensed Consolidated Balance Sheets
(continued)

(dollars in thousands)

	Unaudited June 30, 2011	Note 1 December 31, 2010
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 19,439**	**$ 17,418**
Long-term debt subject to short-term remarketing arrangements	**129,980**	**122,060**
Accounts payable	**149,346**	**166,442**
Accrued salaries and employee benefits	**290,869**	**305,421**
Accrued expenses	**119,583**	**206,874**
Amounts due to primary third-party payors	**266,451**	**237,731**
Current portion of accrued insurance and claims costs	**94,350**	**91,807**
Obligations to return collateral under securities lending program	**18,455**	**219,052**
Total current liabilities	**1,088,473**	**1,366,805**
Noncurrent liabilities:		
Long-term debt, less current portion	**883,041**	**901,091**
Pension plan liability	**33,503**	**34,296**
Accrued insurance and claims costs, less current portion	**688,693**	**679,317**
Accrued losses subject to insurance recovery	**175,184**	**164,074**
Obligations under swap agreements, net of collateral posted	**23,615**	**16,111**
Other noncurrent liabilities	**96,211**	**92,356**
Total noncurrent liabilities	**1,900,247**	**1,887,245**
Total liabilities	**2,988,720**	**3,254,050**
Net assets:		
Unrestricted	**3,597,717**	**3,363,405**
Temporarily restricted	**78,206**	**74,786**
Permanently restricted	**28,922**	**28,794**
Total net assets	**3,704,845**	**3,466,985**
	$ 6,693,565	**$ 6,721,035**

Note 1: December 31, 2010 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2010 Audited Consolidated Financial Statements.

See accompanying notes to condensed consolidated financial statements.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Condensed Consolidated Statements of Operations and Changes in Net Assets

(dollars in thousands)

	Unaudited For the Quarter Ended June 30,		Unaudited For the Six Months Ended June 30,		Note 1 For the Year Ended December 31,
	2011	**2010**	**2011**	**2010**	**2010**
Unrestricted revenues and other support					
Patient service revenue	**$ 966,144**	$ 940,094	**$ 1,896,552**	$ 1,850,709	**$ 3,737,541**
Proceeds from Medicaid assessment	**36,944**	36,946	**73,889**	73,891	**147,781**
Capitation revenue	**111,099**	105,593	**205,624**	203,783	**392,854**
Other revenue	**63,712**	57,439	**117,662**	112,137	**227,464**
	1,177,899	1,140,072	2,293,727	2,240,520	**4,505,640**
Expenses					
Salaries, wages and employee benefits	**552,099**	529,061	**1,082,902**	1,048,947	**2,137,097**
Purchased services and operating supplies	**264,461**	262,273	**523,929**	514,809	**1,053,932**
Contracted medical services	**48,309**	45,606	**92,513**	89,457	**180,921**
Provision for uncollectible accounts	**55,864**	52,316	**114,281**	106,780	**212,536**
Insurance and claims costs	**33,806**	32,728	**70,269**	81,672	**46,422**
Other	**59,689**	53,912	**114,350**	105,885	**223,066**
Medicaid assessment	**26,514**	26,585	**53,104**	53,135	**106,274**
Depreciation and amortization	**42,505**	41,120	**83,702**	83,206	**164,984**
Interest	**11,033**	11,511	**21,952**	23,124	**45,205**
	1,094,280	1,055,112	**2,157,002**	2,107,015	**4,170,437**
Operating income	**83,619**	84,960	**136,725**	133,505	**335,203**
Nonoperating income (loss)					
Investment income (losses)	**18,726**	(101,870)	**99,222**	(24,703)	**285,560**
Change in the fair value of interest rate swaps	**(7,407)**	(25,713)	**(276)**	(26,924)	**(14,335)**
Other nonoperating items, net	**(3,186)**	(3,774)	**(3,446)**	(7,238)	**(17,447)**
Excess of fair value of assets over liabilities assume	**-**				
in the acquisition of BroMenn Healthcare System	**-**	(702)	**-**	225,037	**225,541**
Loss on refinancing of debt	**-**	(14)	**-**	(453)	**(453)**
	8,133	(132,073)	**95,500**	165,719	**478,866**
Revenues in excess (less than) expenses	**$ 91,752**	$ (47,113)	**$ 232,225**	$ 299,224	**$ 814,069**

***Note 1**: December 31, 2010 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2010 Audited Consolidated Financial Statements.*

See accompanying notes to condensed consolidated financial statements.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Condensed Consolidated Statements of Operations and Changes in Net Assets
(continued)
(dollars in thousands)

	Unaudited For the Quarter Ended June 30,		Unaudited For the Six Months Ended June 30,		Note 1 For the Year Ended December 31,
	2011	**2010**	**2011**	**2010**	**2010**
Unrestricted net assets					
Revenues in excess (less than) expenses	**$ 91,752**	$ (47,113)	**$ 232,225**	$ 299,224	**$ 814,069**
Contributions received from a supporting foundation and grants used for capital purposes	**876**	60	**2,087**	140	**8,716**
Post retirement benefit plan adustments	**-**	-	**-**	-	**25,137**
Increase (decrease) in unrestricted net assets	**92,628**	(47,053)	**234,312**	299,364	**847,922**
Temporarily restricted net assets					
Contributions for medical education programs, capital purchases, and other purposes	**3,440**	2,894	**5,789**	4,868	**11,789**
Realized gains on investments	**365**	465	**684**	266	**1,199**
Unrealized gains (losses) on investments	**267**	(1,852)	**1,205**	(693)	**3,524**
Contribution received in acquisition of BroMenn Healthcare System	**-**	-	**-**	9,732	**9,814**
Net assets released from restrictions and used for operations, for capital purposes, for medical education programs and other purposes	**(2,123)**	(1,902)	**(4,258)**	(3,363)	**(16,254)**
Increase (decrease) in temporarily restricted net assets	**1,949**	(395)	**3,420**	10,810	**10,072**
Permanently restricted net assets					
Contributions for medical education programs, capital purchases, and other purposes	**48**	307	**128**	348	**998**
Contribution received in acquisition of BroMenn Healthcare System	**-**	-	**-**	7,716	**10,223**
Increase in permanently restricted net assets	**48**	307	**128**	8,064	**11,221**
Increase (decrease) in net assets	**94,625**	(47,141)	**237,860**	318,238	**869,215**
Net assets at beginning of period	**3,610,220**	2,963,149	**3,466,985**	2,597,770	**2,597,770**
Net assets at end of period	**$ 3,704,845**	$2,916,008	**$ 3,704,845**	$ 2,916,008	**$ 3,466,985**

Note 1: December 31, 2010 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2010 Audited Consolidated Financial Statements.

See accompanying notes to condensed consolidated financial statements.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Condensed Consolidated Statements of Cash Flows
(dollars in thousands)

	Unaudited For the Quarter Ended June 30,		Unaudited For the Six Months Ended June 30,		Note 1 For the Year Ended December 31,
	2011	2010	2011	2010	2010
Operating activities					
Increase (decrease) in net assets	**$ 94,625**	$ (47,141)	**$ 237,860**	$ 318,238	**$ 869,215**
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:					
Depreciation, amortization and accretion	**42,855**	41,394	**84,318**	83,753	**166,077**
Provision for uncollectible accounts	**55,864**	52,316	**114,281**	106,780	**212,536**
Deferred income taxes	**-**	3,000	**-**	4,000	**16,303**
Losses (gains) on disposal of property and equipment	**2,161**	113	**2,353**	(1,073)	**(1,989)**
Loss on refinancing of debt	**-**	14	**-**	453	**453**
Change in fair value of interest rate swaps	**7,407**	25,713	**276**	26,924	**14,335**
Postretirement benefit plan adjustments	**-**	-	**-**	-	**(25,138)**
Contribution of certain net assets received in the acquisition of BroMenn BroMenn Healthcare System	**-**	702	**-**	(242,485)	**(245,578)**
Restricted contributions and gains on investments, net of assets released from restrictions used for operations	**(1,248)**	(1,842)	**(2,171)**	(3,223)	**(7,538)**
Change in operating assets and liabilities:					
Trading securities	**(266,577)**	58,756	**(376,285)**	(147,925)	**(759,060)**
Patient accounts receivable	**(38,160)**	(55,913)	**(129,220)**	(107,977)	**(246,997)**
Amounts due to/from primary third-party payors	**(9,092)**	13,336	**25,252**	34,722	**47,926**
Accounts payable, accrued salaries, employee benefits, accrued expenses and other noncurrent liabilities	**17,816**	(19,074)	**(116,052)**	(48,199)	**149,081**
Other assets	**(369)**	8,737	**3,001**	(14,894)	**(54,340)**
Accrued insurance and claims costs	**15,198**	9,174	**11,919**	51,531	**(39,384)**
Net cash (used in) provided by operating activities	**(79,520)**	89,285	**(144,468)**	60,625	**95,902**
Investing activities					
Purchases of property and equipment	**(64,612)**	(46,504)	**(122,950)**	(70,653)	**(178,656)**
Proceeds from sale of property and equipment	**762**	234	**1,010**	1,792	**6,929**
Cash acquired in the acquistion of BroMenn Healthcare System	**-**	-	**-**	5,031	**4,918**
Purchase of certain net assets of Physician groups	**(108)**	-	**(768)**	-	**-**
Net sales and purchases of investments designated as nontrading	**348**	12,341	**1,208**	(19,222)	**33,438**
Other	**1,094**	3,561	**(4,109)**	(984)	**(6,089)**
Net cash used in investing activities	**(62,516)**	(30,368)	**(125,609)**	(84,036)	**(139,460)**
Financing activities					
Proceeds from issuance of debt	**-**	-	**-**	243,746	**243,746**
Payment of long-term debt	**(436)**	(5,662)	**(7,877)**	(154,443)	**(173,456)**
Collateral returned or posted under interest rate swap agreements	**(11,438)**	(10,031)	**7,227**	13,242	**3,930**
Proceeds from restricted contributions and gains on investments	**4,120**	1,814	**7,806**	4,789	**17,510**
Net cash (used in) provided by financing activities	**(7,754)**	(13,879)	**7,156**	107,334	**91,730**
(Decrease) Increase in cash and cash equivalents	**(149,790)**	45,038	**(262,921)**	83,923	**48,172**
Cash and cash equivalents at beginning of period	**428,871**	532,715	**542,002**	493,830	**493,830**
Cash and cash equivalents at end of period	**$ 279,081**	$ 577,753	**$ 279,081**	$ 577,753	**$ 542,002**

Note 1: December 31, 2010 financial statement information was derived from and should be read in conjunction with the Advocate Health Care Network and Subsidiaries 2010 Audited Consolidated Financial Statements.

See accompanying notes to condensed consolidated financial statements.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Notes to Interim Condensed Consolidated Financial Statements

As of and for the Second Quarter Ended June 30, 2011

(dollars in thousands except as noted)

Note A - Basis of Presentation

The accompanying condensed consolidated financial statements for the second quarters ended June 30, 2011 and 2010 have been prepared in accordance with accounting principles generally accepted in the United States applied on a basis substantially consistent with that of the 2010 audited consolidated financial statements of Advocate Health Care Network and Subsidiaries ("Advocate"). In the opinion of management, all adjustments (consisting of normal recurring accruals) considered necessary for a fair presentation have been included. The condensed consolidated financial statements do not include all of the information and footnotes required by accounting principles generally accepted in the United States for complete financial statements. Operating results for the quarter and six months ended June 30, 2011 are not necessarily indicative of the results that may be experienced during the year ending December 31, 2011.

The condensed consolidated balance sheet, statement of operations and changes in net assets and statement of cash flows at December 31, 2010 and for the year then ended have been derived from the 2010 audited consolidated financial statements of Advocate, but do not include all of the information and footnotes required by accounting principles generally accepted in the United States for complete financial statements.

Note B - Accounting Pronouncements

New Accounting Pronouncements

On January 1, 2010, Advocate adopted the authoritative guidance issued by the Financial Accounting Standards Board (the "FASB") on not-for-profit mergers and acquisitions. This guidance did not have a material impact on the manner in which Advocate has historically fair valued assets acquired and liabilities assumed as a result of business combinations. The guidance requires that the net fair value of assets acquired and liabilities assumed be reported as a component of revenues in excess of expenses in the consolidated statement of operations and changes in net assets.

On January 1, 2010, Advocate adopted the authoritative guidance issued by the FASB to amend the disclosure requirements related to recurring and nonrecurring fair value measurements. The guidance requires new disclosures on the transfers of assets and liabilities between Level 1 (quoted prices in active market for identical assets or liabilities) and Level 2 (significant other observable inputs) of the fair value measurement hierarchy, including the reasons and the timing of the transfers. Additionally, the guidance requires a roll forward of activities on purchases, sales, issuance and settlements of assets and liabilities measured using significant unobservable inputs (Level 3 fair value measurements). The guidance was effective for Advocate January 1, 2010, except for the disclosure on the roll forward activities for Level 3 fair value measurements, which became effective for Advocate on January 1, 2011. Other than requiring additional disclosures, adoption of this new guidance did not have a material impact on Advocate's financial statements.

On January 1, 2011, The FASB issued guidance to clarify for health care entities that estimated insurance recoveries should not be netted against related claim liabilities. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. The guidance was effective for Advocate with the reporting period beginning on January 1, 2011. As Advocate was already following this guidance prior to 2011, there was no impact on Advocate's financial statements.

Recent Accounting Guidance Not Yet Adopted

In July 2011, the FASB issued guidance requiring reclassifying the provision for bad debts associated with patient revenue from an operating expense to a deduction from patient service revenue. Additionally the guidance requires enhanced disclosure about policies for recognizing revenue, assessing bad debts, and qualitative and quantitative information about changes in the allowance for doubtful accounts. The guidance is effective for Advocate with the reporting period beginning January 1, 2012, with early adoption permitted. If the guidance would have been adopted June 30, 2011, net patient service revenue would be $910.3 million and $887.8 million for the quarters ended June 30, 2011 and 2010, respectively; $1,782.3 million and $1,743.9 million for the six months ended June 30, 2011 and 2010, respectively; and $3,525.0 million for the year ended December 31, 2010.

In May 2011, the FASB issued guidance to amend disclosure requirements related to fair value measurement. The guidance expands disclosures for Level 3 fair value measurements, addresses nonfinancial assets highest and best use, and permits fair value adjustments for assets and liabilities with offsetting risks. The guidance is effective for Advocate with the reporting period beginning January 1, 2012. Other than requiring additional disclosures, adoption of this new guidance will not have a material impact on Advocate's financial statements.

In August 2010, the FASB issued guidance requiring that cost be used as the measurement basis for charity care disclosure purposes. The method used to identify the direct and indirect costs of providing the charity care must be disclosed. The guidance is effective for Advocate's 2011 fiscal year financial statements. Other than requiring additional disclosures, adoption of this new guidance will not have a material impact on Advocate's financial statements.

Note C – Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates, assumptions and judgments that affect the reported amounts of assets and liabilities and amounts disclosed in the notes to the financial statements at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Although estimates are considered to be fairly stated at the time made, actual results could differ materially from those estimates.

Advocate considers critical accounting policies to be those that require the more significant judgments and estimates in the preparation of its financial statements, including, but not limited to, the following: recognition of patient service revenue, which includes, contractual allowances, third-party payor settlements, contracted medical service expense recognition and reserves for incurred but not reported claims; accounting for asset impairment or disposal of long-lived assets; provisions for uncollectible accounts and charity care allowances; reserves for losses and expenses related to health care professional, general and other self-insured liability risks; analysis of potential other than temporary declines in fair value of non-trading investments; accounting for swap valuations; and pension plan actuarial assumptions. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Although estimates are considered to be reasonable at the time made, actual results could differ materially from those estimates.

Changes in estimates that relate to prior years' payment arrangements resulted in increases to net patient service revenue of $1.7 million and $3.0 million for the quarters ended June 30, 2011 and 2010 respectively; $4.8 million and $3.8 million for the six months ended June 30, 2011 and 2010, respectively; and $17.8 million for the year ended December 31, 2010.

Note D – Retirement Plans

Advocate maintains defined benefit pension plans ("Plans") that cover substantially all of its employees ("associates").

Pension plan liabilities as of June 30, 2011 and December 31, 2010 amounted to $33.5 million and $34.3 million, respectively. Pension plan expense included in the condensed consolidated statements of operations and changes in net assets is as follows:

	For the Quarter Ended June 30,		For the Six Months Ended June 30,		For the Year Ended December 31,
	2011	2010	**2011**	2010	**2010**
Service cost	**$9,571**	$9,276	$19,142	$18,553	**$37,104**
Interest cost	**9,753**	9,526	19,506	19,053	**38,106**
Expected return on plan assets	**(14,072)**	(13,585)	(28,144)	(27,171)	**(54,340)**
Amortization of:					
Actuarial loss	**1,848**	1,275	3,696	2,550	**5,100**
Prior service cost (credit)	**(1,206)**	(1,227)	(2,412)	(2,455)	**(4,910)**
Settlement/curtailment	**-**	-	-	-	**767**
Net pension expense	**$5,894**	$5,265	$11,788	$10,530	**$21,827**

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Amounts funded into the Plans were paid from employer assets and were as follows (there were no contributions other than cash to the Plans):

	For the Quarter Ended June 30,		For the Six Months Ended June 30,		For the Year Ended December 31,
	2011	2010	**2011**	2010	**2010**
Cash contributions	**$7,005**	$5,580	**$14,010**	$11,400	**$22,560**

At this time, subject to investment returns, Advocate anticipates making $28.0 million in contributions to the Plans during 2011. Expected associate benefit payments from the plans' assets are $46.4 million in 2011; $50.5 million in 2012; $51.9 million in 2013; $54.1 million in 2014; $57.7 million in 2015 and $335.7 million for the years 2016 through 2019.

Advocate's target and actual allocation of the Plans' assets are as follows:

	Strategic Target	**June 30, 2011**	**December 31, 2010**
Domestic and international equity securities	42.5%	48.0%	50.7%
Fixed income securities	30.0	28.1	29.7
Real estate	10.0	8.7	7.1
Private equity limited partnerships	10.0	7.7	7.4
Hedge funds	7.5	7.5	5.1
	100.0%	100.0%	100.0%

The investment policy, as amended in June 2011, generally establishes the target asset allocation among the following styles: 42.5 % to large and mid capitalization equity; non-large capitalization equities; international and emerging marketable equities; 30.0% to fixed income; 10.0% real estate; 10.0% private equity investments; and 7.5% hedge funds. Assets of the Plans are managed by a number of external investment professionals. In order to minimize risk and achieve further diversification, limitations are placed on investment managers as to the overall amount that can be invested in one issuer (except for U.S. government obligations and its agencies) or economic sector.

Assumptions used to determine benefit obligations are as follows:

	June 30, 2011	**December 31, 2010**
Discount rate	**5.4%**	5.4%
Assumed rate of return on assets	**8.0%**	8.0%

To develop the long-term rate of return on plan assets assumption, Advocate considered the current level of expected returns on risk free investments (primarily government bonds), the historical level of the risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns of each asset class. The expected return for each asset class was then weighted based on the strategic target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. This resulted in the selection of an 8.0% rate of return for 2011 and 2010. For comparative purposes, the ten-year historical return on plan assets for the period ended June 30, 2011 was 5.9%.

In addition to the Plans, Advocate sponsors various defined contribution plans for its associates. Contributions to these plans, that are included in salaries, wages and employee benefits expense in the condensed consolidated statements of operations and changes in net assets, were as follows:

	For the Quarter Ended June 30,		For the Six Months Ended June 30,		For the Year Ended December 31,
	2011	2010	**2011**	2010	**2010**
Defined contribution plan expense	**$5,894**	$5,612	**$11,788**	$14,176	**$35,042**

Note E – Long-Term Debt

Advocate's unsecured variable rate revenue bonds, Series 2003C of $27.7 million and Series 2008 (A-1 and A-3) of $102.3 million, while subject to a long-term amortization period, may be put to Advocate at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after June 30, 2011, the principal amount of such bonds has been classified as a current obligation in the accompanying condensed consolidated balance sheets. To address the possibility that a material amount of these bonds would be put back to Advocate, management has taken steps to provide various sources of liquidity in such event, including maintaining unrestricted assets as a source of self-liquidity and lines of credit with banks.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

All outstanding bonds were issued pursuant to a Master Trust Indenture dated as of December 1, 1996 (the Master Indenture), as subsequently amended between Advocate and Bank of New York Mellon Trust Company, N.A. as master trustee. Under the terms of the Master Indenture and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The Master Indenture and other debt agreements, including bank credit agreements, also place restrictions on Advocate and require Advocate to maintain certain financial ratios. Interest paid, net of capitalized interest, amounted to $20.0 million and $17.6 million for the six months ended June 30, 2011 and 2010 respectively, and $38.6 million for the year ended December 31, 2010. Advocate capitalized interest of approximately $1.9 million and $0.9 million for the six months ended June 30, 2011 and 2010, respectively and $2.3 million for the year ended December 31, 2010.

In connection with the BroMenn Healthcare System and Subsidiaries ("BRMC") merger and other capital and debt management items, the Illinois Finance Authority, on behalf of Advocate, issued $238.3 million of Series 2010 Bonds. The proceeds of the Series 2010 Bonds were used, together with other available funds, to (i) pay the costs related to the merger and the costs related to the construction, renovation and equipping of a new BRMC patient tower, (ii) finance, refinance or reimburse Advocate for a portion of the costs related to the acquisition, construction, renovation and equipping of certain capital projects, (iii) refund the Illinois Finance Authority Revenue Refunding Bonds, Series 2008B and (iv) pay certain costs of issuing the Series 2010 Bonds and refunding the Prior Bonds. The official statement for the Series 2010 Bonds is available on the EMMA – Electronic Municipal Market Access website (www.emma.msrb.org).

On April 29, 2008, the Illinois Finance Authority, on behalf of Advocate, issued uninsured variable rate bonds, Series 2008 A, B and C in the amount of $624.2 million. The proceeds were used to refund the Series 2005 and Series 2007 insured auction rate securities in the amount of $623.2 million. In connection with the issuance of the Series 2008 B and C Bonds, Advocate transferred multiple floating-to-fixed interest rate swap agreements, which were previously attached to the Series 2005 and Series 2007B Bonds, effectively converting the variable rate demand bonds to fixed rates of 3.20% and 3.605%. The Series 2008B Bonds were redeemed on January 6, 2010 as part of the Series 2010D Bond issuance and the related Series 2008B Swaps agreements were terminated on December 6, 2009. Additional information on Advocate interest rate swap program on certain of its variable rate debt is described in Note H – Derivatives, and also in the Guarantees of Debt, Swaps and Other Derivatives and Financing Arrangements section of the Management Discussion and Analysis of Financial Condition and Results of Operations.

Maturities of long-term debt and sinking fund requirements at June 30, 2011, assuming remarketing of the variable rate demand revenue refunding bonds (See Liquidity and Capital Resources section of the Management Discussion and Analysis of Financial Condition and Results of Operations for further description of variable rate demand bonds' remarketing terms) for the five years ending June 30, 2016 are as follows: 2012 - $19.4 million; 2013 - $23.0 million; 2014 - $21.2 million; 2015 - $19.2 million; and 2016 - $21.4 million.

At June 30, 2011 Advocate had lines of credit with banks aggregating to $200.0 million. These lines of credit provide for various interest rates, payment terms and expire as follows, $50.0 million in December 2011, $25.0 million in March 2012, $75.0 million in March 2013 and $50.0 million in November 2013. These lines of credit may be used to redeem bonded indebtedness, pay costs related to such redemptions, for capital expenditures or for general working capital purposes. At June 30, 2011 and December 31, 2010 no amounts were outstanding on these lines of credit.

Note F - Investments

Please refer to the Investment Program section of the Management Discussion and Analysis of Financial Condition and Results of Operations for a description of Advocate's investment policy, allocation of investments and overall yields.

Substantially all investments and assets limited as to use are classified as trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices. Investments in limited partnerships that invest in marketable securities and derivative products ("hedge funds") are reported using the equity method of accounting based on information provided by the respective partnership. Investments in private equity limited partnerships are recorded using the cost method of accounting. Advocate regularly compares the net asset value ("NAV"), which is a proxy for the fair value of its private equity investments, to the recorded cost for potential other than temporary impairment. Advocate did not identify any impairment of these investments at June 30, 2011 or at December 31, 2010. The NAV of these investments based on estimates determined by the investments' management was $190.8 million and $173.5 million at June 30, 2011 and December 31, 2010, respectively.

Investment income or loss (including realized gains and losses, interest, dividends, changes in equity of limited partnerships, and unrealized gains and losses) is included in investment income unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue. Gains and losses which are restricted by donor or law are reported as a change in temporarily restricted net assets.

Investment returns for assets limited as to use, cash and cash equivalents and short term investments are comprised of the following:

	For the Quarter Ended June 30,		For the Six Months Ended June 30,		For the Year Ended December 31,
	2011	2010	**2011**	2010	**2010**
Interest and dividend income	**$ 23,680**	$ 9,782	**$ 44,331**	$ 21,532	**$ 79,511**
Net realized gains	**30,243**	41,171	**56,226**	62,046	**89,063**
Net change in unrealized gains (losses)	**(19,853)**	(139,114)	**28,925**	(79,785)	**182,750**
	$ 34,070	$ (88,161)	**$ 129,482**	$ 3,793	**$ 351,324**

Investment returns are included in the consolidated statements of operations and changes in net assets as follows

	For the Quarter Ended June 30,		For the Six Months Ended June 30,		For the Year Ended December 31,
	2011	2010	**2011**	2010	**2010**
Other revenue	**$ 14,712**	$ 15,095	**$ 28,371**	$ 28,923	**$ 61,041**
Investment income	**18,726**	(101,870)	**99,222**	(24,703)	**285,560**
Temporarily resticted net assets realized and change in unrealized gains	**632**	(1,386)	**1,889**	(427)	**4,723**
	$ 34,070	$ (88,161)	**$ 129,482**	$ 3,793	**$ 351,324**

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Investments in hedge funds totaled $372.1 million at June 30, 2011 and $294.0 million at December 31, 2010. Investments in private equity limited partnerships totaled $167.7 million at June 30, 2011 and $163.4 million at December 31, 2010. Advocate does not believe that these investments are impaired and therefore has not recognized an impairment loss in the condensed consolidated statements of operations and changes in net assets for either the six months ended June 30, 2011 or year ended December 31, 2010.

At June 30, 2010 Advocate has commitments to fund an additional $199.0 million to private equity limited partnerships over approximately the next six years. Additional allocations of investments are anticipated to be made to private equity limited partnerships in the future as opportunities arise.

Note G - Fair Value Measurements

Advocate accounts for certain assets and liabilities at fair value. The hierarchy below lists three levels of fair value based on the extent to which inputs used in measuring fair value are observable in the market. Advocate categorizes each fair value measurement in one of three levels based on the lowest level input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices in active markets for identified assets or liabilities.
Level 2: Inputs, other than the quoted process in active markets, that are observable either directly or indirectly.
Level 3: Unobservable inputs in which there is little or no market data which then requires the reporting entity to develop its own assumptions about what market participants would use in pricing the asset or liability.

The following section describes the valuation methodologies Advocate uses to measure financial assets and liabilities at fair value. In general, where applicable, Advocate uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments such as domestic and international equities, U.S. Treasuries, exchange-traded mutual funds, and agency securities. If quoted prices in active markets for identical assets and liabilities are not available to determine fair value then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, commercial paper, and certain agency securities. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include adjustments related to Advocate's credit risk.

Advocate's investments are exposed to various kinds and levels of risk. Equity securities and equity mutual funds expose Advocate to market risk, performance risk and liquidity risk for both domestic and international investments. Market risk is the risk associated with major movements of the equity markets. Performance risk is that risk associated with a company's operating performance. Fixed income securities and fixed income mutual funds expose Advocate to interest rate risk, credit risk and liquidity risk. As interest rates change, the value of many fixed income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value resulting in additional gains and losses in the near term.

The following are assets and liabilities measured at fair value on a recurring basis at June 30, 2011 and December 31, 2010:

Description	June 30, 2011	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 367,474	$ 314,648	$ 52,826	$ -
Corporate bonds and other debt securities	266,760	-	266,760	-
United States goverment obligations	220,044	-	220,044	-
Government mutual funds	196,001	-	196,001	-
Bond and other debt security mutual funds	871,413	-	871,413	-
Commodity mutual funds	3,609	-	3,609	-
Equity securities	933,438	933,438	-	-
Equity mutual funds	519,257	314,042	205,215	-
Real estate	38,456	-	35,000	3,456
Investment at fair value	**3,416,452**	**1,562,128**	**1,850,868**	**3,456**
Investment not at fair value	**539,828**			
Total investments	**$ 3,956,280**			
Collateral proceeds received under securities lending program	**$ 18,180**		**$ 18,180**	
Liabilities				
Derivatives:				
Obligations under interest rate swap agreements	$ (44,356)	$ -	$ (44,356)	$ -
Collateral under interest rate swap agreements	20,741	-	20,741	-
Liability under interest rate swap agreements	**$ (23,615)**	**$ -**	**$ (23,615)**	**$ -**
Obligations to return capital under securities lending program	**$ (18,455)**	**$ -**	**$ (18,455)**	**$ -**

Description	December 31, 2010	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 709,469	$ 607,254	$ 102,215	$ -
Corporate bonds and other debt securities	160,117	-	160,117	-
United States goverment obligations	115,720	-	115,720	-
Government mutual funds	119,446	-	119,446	-
Bond and other debt security mutual funds	912,584	2,079	910,505	-
Commodity mutual funds	3,770	-	3,770	-
Equity securities	948,189	948,189	-	-
Equity mutual funds	423,085	367,212	55,873	-
Investment at fair value	**3,392,380**	**1,924,734**	**1,467,646**	**-**
Investment not at fair value	**457,378**			
Total investments	**$ 3,849,758**			
Collateral proceeds received under securities lending program	**$ 218,777**		**$ 218,777**	
Liabilities				
Derivatives:				
Obligations under interest rate swap agreements	$ (44,080)	$ -	$ (44,080)	$ -
Collateral under interest rate swap agreements	27,969	-	27,969	-
Liability under interest rate swap agreements	**$ (16,111)**	**$ -**	**$ (16,111)**	**$ -**
Obligations to return capital under securities lending program	**$ (219,052)**		**$ (219,052)**	

The table below sets forth a summary of changes in the fair value of the Level 3 assets for 2011:

	Real Estate
Fair value at December 31, 2010	$ -
Net purchases and sales	3,456
Fair value at June 30, 2011	$ 3,456

The estimated fair value of long-term debt based on quoted market prices for the same or similar issues was $1,025.0 million and $1,060.8 million at June 30, 2011 and December 31, 2010, respectively, which includes consideration of third-party credit enhancements, for which there was no impact. The carrying value of long-term debt was $1,032.5 million and $1,040.6 million at June 30, 2011 and December 31, 2010, respectively.

Note H – Derivatives

Advocate has interest rate related derivative instruments to manage its exposure on its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management purposes. By using derivative financial instruments to manage the risk of changes in interest rates, Advocate exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes Advocate, which creates credit risk for Advocate. When the fair value of a derivative contract is negative, Advocate owes the counterparty and, therefore, it does not possess credit risk. Advocate minimizes the credit risk in derivative instruments by entering into transactions that require the counterparty to post collateral for the benefit of Advocate based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be under taken. Advocate also mitigates risk through periodic reviews of their derivative positions in the context of their total blended cost of capital.

Advocate maintains interest rate swap programs on its Series 2008C Bonds. The Series 2008C Bonds expose Advocate to variability in interest payments due to changes in interest rates. Advocate believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, Advocate entered into various swap agreements to manage fluctuations in cash flows resulting from interest rate risk. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in principal amounts of the Series 2008C Bonds. The following is a summary of the terms of these interest rate swap agreements at June 30, 2011:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	$129,900	11/1/2038	61.7% of LIBOR + 26 bps	3.60%
2008C-2	$108,425	11/1/2038	61.7% of LIBOR + 26 bps	3.60%
2008C-3	$ 88,000	11/1/2038	61.7% of LIBOR + 26 bps	3.60%

The swaps have not been designated as hedging instruments and therefore hedge accounting has not been applied. As such, unrealized changes in fair value of the swaps are included as a component of nonoperating income (loss) in the condensed consolidated statements of operations and changes in net assets as changes in the fair value of interest rate swaps. The net cash settlement payments, representing the realized changes in fair value of the swaps are included as interest expense in the condensed consolidated statements of operations and changes in net assets.

The fair value of derivative instruments at June 30, 2011 and December 31, 2010 was as follows:

Condensed Consolidated Balance Sheet Location	**June 30, 2011**	December 31, 2010
Obligations under swap agreements	$ **(44,356)**	$ (44,080)
Collateral posted under swap agreements	**20,741**	27,969
Obligations under swap agreements, net	$ **(23,615)**	$ (16,111)

Amounts recorded in the condensed consolidated statements of operations and changes in net assets for the interest rate swaps are as follows:

Condensed Consolidated Statement of Operations And Changes in Net Assets Location	For the Quarter Ended June 30, **2011**	2010	For the Six Months Ended June 30, **2011**	2010	For the Year Ended December 31, **2010**
Net cash payments on interest rate swap agreements (interest expense)	**$2,624**	$2,566	**$5,252**	$5,318	**$10,429**
Change in the fair value of interest rate swap agreements (nonoperating)	**$7,407**	$25,713	**$(276)**	$26,924	**$(14,335)**

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate's swap instruments contain provisions that require Advocate to maintain an investment grade credit rating on its tax-exempt bonds from certain major credit rating agencies. If Advocate's tax-exempt bonds were to fall below investment grade on the valuation date, it would be in violation of these provisions, and the counterparty to the derivative instruments could request immediate payment or demand immediate and ongoing full collateralization on derivative instruments in net liability positions. At June 30, 2011 and December 31, 2010, the estimated mid-market value of the swap was negative to Advocate by $44.3 million and $44.1 million respectively, for which Advocate has posted collateral of $20.7 million and $28.0 million, at June 30, 2011 and December 31, 2010, respectively, in the normal course of business. If the credit-risk-related contingent features underlying these swap agreements were triggered on June 30, 2011, Advocate would be required to post an additional $23.6 million collateral to the counterparty.

Note I – Subsequent Events

Advocate evaluated events occurring between July 1, 2011, and August 26, 2011 which is the date when the condensed consolidated financial statements were issued. During this period there were no subsequent events that required recognition in the condensed consolidated financial statements. Additionally, there were no unrecognized subsequent events that required disclosure.

The Condensed Consolidated Financial Statements were prepared on July 15, 2011.

Advocate Health Care Network and Subsidiaries
Management Discussion and Analysis of Financial Condition and Results of Operations

This Management Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with the Condensed Consolidated Financial Statements for the Second Quarter Ended June 30, 2011.

Organizational Overview

Advocate Health Care Network and Subsidiaries, ("Advocate"), based in Oak Brook, Illinois is the largest health care provider in the State of Illinois.

Advocate Health Care Network ("AHCN") is the sole member of Advocate Health and Hospitals Corporation ("AHHC'), and AHHC is the sole member of Advocate North Side Health Network ("North Side") and Advocate Condell Medical Center ("ACMC"). AHCN, AHHC and North Side are also the sole members of various not-for-profit corporations or the shareholders of various business corporations, the primary activities of which are the delivery of health care services or the provision of goods and services ancillary thereto. Such controlled corporations, along with AHCN, AHHC, ACMC and North Side, constitute Advocate. As the parent of Advocate, AHCN currently has no material operations or activities of its own, apart from its ability to control AHHC, ACMC, North Side and other controlled organizations compromising Advocate. All of Advocate's hospitals, except for North Side and ACMC, are owned by AHHC. Advocate's not for profit corporations, including AHCN, AHHC, North Side and ACMC, are exempt from federal income taxation pursuant to Section 501(c)(3) of Internal Revenue Code of 1986, as amended.

Advocate provides a continuum of care through its ten acute care hospitals, two integrated children's hospitals, which in total have approximately 3,200 licensed beds, primary and specialty physician services, outpatient centers, physician office buildings, home health and hospice care in the metropolitan Chicago, IL area and in central Illinois. Advocate has approximately 5,700 physicians on staff. Through a long-term academic and teaching affiliation with the University of Illinois at Chicago Health Sciences Center, Advocate trains more resident physicians than any non-university teaching hospital in Illinois.

Advocate makes operating and financial decisions on a System-wide basis to provide for complete financial integration of Advocate hospitals and other health services. Further, Advocate's overall management is centralized to allow for a streamlined decision making process and the ability of Advocate to respond quickly to market forces. Advocate's management believes it has the greatest geographic coverage with over 200 sites of care as compared to other hospital systems based in the Chicago metropolitan area.

Advocate owns and is affiliated with several large physician groups. Advocate Medical Group is an unincorporated physician group that is a division of both AHHC and North Side, and as of June 30, 2011 employed approximately 421 FTE physicians. Advocate Health Centers, Inc. is an Illinois for profit corporation that is a wholly owned subsidiary of Evangelical Services Corporation d/b/a Advocate Network Services, Inc. ("ESC"), an Illinois for profit corporation wholly owned by Advocate that employs approximately 172 FTE physicians. BroMenn Medical Group is also a wholly owned subsidiary of ESC and employs approximately 56 FTE physicians. Advocate has a management and professional service agreement with Dreyer Medical Group, Ltd., which employs approximately 145 full-time equivalent ("FTE") physicians.

Advocate has also entered into a joint venture, Advocate Health Partners, doing business as Advocate Physician Partners ("APP"), an Illinois not for profit corporation. APP is comprised of the ten (10) hospitals that exist within the Advocate Health Care Network and approximately 3,800 independently practicing and employed physician members. All APP member physicians are on the medical staff of at least one Advocate hospital and a member of the respective Advocate hospital Physician Hospital Organization (PHO). APP operates a clinical integration program funded from the major health insurance plans in the Chicago Metropolitan area and provides managed care contracting services for both the Advocate hospitals and APP member physicians. Advocate views APP as an important vehicle for coordination of patient care and care management, clinical integration and for System-wide managed care contracting. As Advocate does not control a majority of APP membership or governance interests, Advocate's interest in APP is accounted for on an equity basis.

Awards and Recognitions

In July 2011, Advocate was named as one of the nation's Most Wired health systems as announced in *Hospitals & Health Networks Magazine.* The *Hospitals & Health Networks'* Most Wired surveyed more than 1,300 hospitals, or roughly 24 percent of all U.S. hospitals. Only 100 hospitals made the Most Wired list. Additionally, Advocate Christ Medical Center, Advocate Good Samaritan Hospital, Advocate Illinois Masonic Medical Center and Advocate Lutheran General Hospital were ranked in the top 20 hospitals in the Chicago metro area by *U.S. News & World Report.*

In June 2011, Advocate was named one of the nation's top 10 health systems for the third consecutive year by Thomson Reuters. The rankings were based on clinical performance across the entire health system. Thomson Reuters' researchers analyzed the quality and efficiency of 285 health systems and found significant differences between top and bottom performers. Additionally, Advocate Hope Children's Hospital was ranked in the top 50 children's hospitals for cardiology and heart surgery by *U.S. News & World Report.* To create the 2011-12 rankings U.S. News surveyed nearly 180 pediatric centers to obtain clinical data and asked 1,500 doctors 10 pediatric specialties where they would send the sickest children.

In May 2011, Advocate was named to *Becker's Hospital Review* 100 Best Places to work in Healthcare. This list was developed by the publication through nominations and research. The organizations selected demonstrate excellence in providing a work environment that promotes teamwork, professional development and quality patient care. *Becker's Hospital Review* features up-to-date business and legal news and analysis relating to hospitals and health systems.

In April 2011, Advocate was recognized with System for Change Award by Practice Green Health. Only seven other health systems were honored for working cohesively to set system goals, track data, benchmark, and share successes in environmental performance. Additionally, eight Advocate hospitals were honored with 12 different awards for their efforts to reduce their environmental footprint.

In March 2011, Advocate Good Samaritan Hospital, Advocate Illinois Masonic Medical Center and Advocate Lutheran General Hospital were ranked among the Top 100 Hospitals by Thomson Reuters. This prestigious study evaluated quantitative data at 2,900 hospitals across the nation. Recipients were selected on 10 performance criteria including patient mortality, medical complications, costs and readmission rates for certain conditions such as heart attacks. Additionally, Advocate Illinois Masonic Medical Center was ranked one of the best hospitals in Chicago by US News & World Report in the first ever metro hospital ranking. 622 out of 5,000 hospitals across the country were recognized with a record of high performance in key medical specialties. To

qualify, a hospital had to score in the top 25 percent among its peers in a least one of 16 medical specialties—Illinois Masonic scored high in nine specialties.

In February 2011, Advocate BroMenn Medical Center, Advocate Christ Medical Center and Advocate Lutheran General Hospital were named Blue Distinction Centers for Spine Surgery and Hip and Knee Replacements by Blue Cross Blue Shield. Advocate Good Samaritan Hospital and Advocate South Suburban Hospital were named Blue Distinction Centers Hip and Knee Replacements by Blue Cross Blue Shield. Each of the hospitals named as a Blue Distinction Center for Spine Surgery® and/or Hip and Knee Replacement meets objective clinical measures that are developed with input from expert physicians' and medical organizations' recommendations that have resulted in better overall outcomes for patients.

In January 2011, Advocate Health Care was recognized as one of the nation's leading integrated health care networks by SDI. Advocate ranked 10th among 100 health systems earning this honor. The SDI IHN Rating System rates local and regional, non-specialty integrated healthcare networks (IHNs) on their performance level and degree of integration. The rating system is a means for identifying the SDI Top 100 IHNs based on critical success factors. SDI has been tracking the development of the IHN market since April 1994 and surveys the universe of IHNs annually using a standard methodology for collecting the data and rating IHNs nationally.

In December 2010, Advocate Good Samaritan Hospital received the Lincoln Gold Award of Excellence from the Lincoln Foundation. The award is presented to organizations that have demonstrated exemplary approach, deployment and achievement of outstanding results in its overall quality systems and continuous improvement process.

In November 2010, Advocate Good Samaritan Hospital was one of seven organizations selected as recipients of the 2010 Malcolm Baldrige National Quality Award, the nation's highest presidential honor for performance excellence through innovation, improvement and visionary leadership. The 2010 Baldrige Award recipients were selected from a field of 83 applicants. All of the applicants were evaluated rigorously by an independent board of examiners in seven areas: leadership; strategic planning; customer focus; measurement, analysis and knowledge management; workforce focus; process management; and results.

In November 2010, the Chicago Tribune announced that Advocate was named to its "Top Workplaces for 2010" list. This is a list of the best workplaces to work in the Chicago metropolitan area and Advocate was one of twenty large companies to be recognized. Selection to this list is based heavily on employee feedback based on results to surveys sent to 5,000 random Advocate associates.

In November 2010, Thomson Reuters announced that Advocate Good Samaritan Hospital has been named a Top 50 Hospital for Cardiovascular Services. Advocate Good Samaritan Hospital was one of fifteen community hospitals to receive this recognition and just one of two hospitals in Illinois to be so honored.

Mission and Community Benefit

As a faith-based health care organization, affiliated with the United Church of Christ and Evangelical Lutheran Church in America, the mission, values and philosophy of Advocate form the foundation for its strategic priorities. Advocate's mission is to serve the health care needs of individuals, families and communities through a wholistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. Consistent with its mission, Advocate is committed to providing each patient with quality care and service, and treats each patient with respect, integrity and dignity.

Through its values of compassion and stewardship, Advocate provides free or discounted care to uninsured and underinsured patients who are eligible for assistance. Each individual's situation is assessed when a patient meets with a financial counselor. If the patient does not qualify for any public assistance programs, such as Medicaid and KidCare, then the patient must complete a charity care application. The program provides free care for patients with annual incomes up to 200% of the federal poverty level, and discounts for the uninsured with annual incomes between 200% and 600% of the federal poverty level. Discounts are available for insured patients with annual incomes between 200% and 400% of the federal poverty level. Each hospital has a multi-disciplinary charity care committee, some with community representatives participating, to oversee the application of Advocate's charity care program. Ninety-nine percent (99%) of completed charity care applications are approved.

The cost to Advocate of providing uncompensated care to the uninsured, underinsured and unreimbursed cost of government sponsored programs is as follows (dollars in thousands):

	Year Ended December 31, [1]	
	2010	2009
Charity care	$ 62,128	$ 48,384
Uncollectible accounts	60,624	37,136
Unreimbursed government sponsored indigent health care	237,979	274,070
Total Costs of Uncompensated Care	$ 360,731	$ 359,590

1 Filed with the State of Illinois Attorney General's office in accordance with the State of Illinois' Community Benefit Act.

The total cost of uncompensated care represents the largest portion of the total of all community benefits provided by Advocate. Total uncompensated care costs increased from 2009 to 2010 due to the addition of Advocate BroMenn, improved identification of those eligible for charity care and the continued poor economy which forced more individuals into financial difficulty which qualified them for charity care or resulted in increased bad debts. These increases were partially offset by receipt of Medicaid stimulus funds, expense management, and lower insurance costs.

In addition, Advocate is involved in numerous activities and programs reaching beyond the walls of its hospitals and into the community. These activities are wide-ranging and include providing community health education, immunizations for children and seniors, support groups, health screenings, health fairs, pastoral care and parish nursing, home-delivered meals, transportation services, seminars and speakers, community meeting space, crisis lines, spirituality newsletters, newspaper and magazine articles regarding current health issues, medical residency and internships, education to other health professionals such as nurses and pharmacy technicians, research and language assistance, dental van for special needs patients, counseling for hospice patients and their families, and many other subsidized health services. Most of these programs and activities are provided either free of charge or for a fee less than the cost of providing them. The cost of providing these other community benefits totaled $113.1 million in 2010.

The Patient Protection and Affordable Care Act ("Health Care Reform Act"), see below, imposes requirements on tax-exempt hospitals to develop, implement and monitor charity care policies and procedures. In addition one of the objectives of the Health Care Reform Act has been to extend the availability and affordability of health care insurance to those segments of the population who have not been able to afford health care insurances or who have not had access to health care services. As a consequence, a reduction in the volume of patients who have historically been afforded care under indigent care programs is probable starting with the federal fiscal year of 2015.

Employees

As of June 30, 2011, Advocate employed approximately 30,700 employees (approximately 25,900 FTEs). Advocate's Management believes that the salary levels and benefits packages for its employees are competitive and that Advocate's managers generally have good relationships with their employees. Less than one tenth of one percent (0.1%) are represented by collective bargaining groups. Advocate was named by the Chicago Tribune as one of the "Top Workplaces for 2010". This is a list of the best workplaces to work in the Chicago Metropolitan area.

Advocate, along with other healthcare providers, has been the target of unions attempting to organize associates. Unions have employed various tactics to either directly attract associates or engage in corporate campaign strategies that are designed to undermine the credibility and integrity of the targeted healthcare providers. Management cannot predict with any certainty whether union organizing related activities will have any material adverse effect on the financial condition or operations of Advocate.

In recent years, the health care industry has suffered from a scarcity of nursing and other qualified health care technicians and personnel. This scarcity may intensify if utilization of health care services increases as a consequence of the expansion of the number of insured consumers occurs as anticipated as a consequence of the Health Care Reform Act. This trend could force Advocate to pay higher salaries to nursing and other qualified health care technicians and personnel as competition for such employees intensifies and, in an extreme situation, could lead to difficulty in keeping the facilities licensed to provide nursing care and thus eligible for reimbursement under Medicare and Medicaid.

Environment and Competition

The health care industry is subject to significant regulatory requirements of federal, state and local governmental agencies and independent professional organizations and accrediting bodies, technological advances, changes in treatment modes, various competitive factors and changes in third-party reimbursement programs.

In the Chicago metropolitan area, which includes the counties of Cook, DuPage, Will, Kane, Lake and McHenry, ten hospitals and/or health care systems have an inpatient market share of 3.0% or higher. For the years ended December 31, 2010 and 2009, Advocate's market share was 15.6% and 15.1%, respectively and for the rolling year ended March 31, 2011 was 15.6%. Market share data is derived from Advocate's analysis of the Illinois Hospital Association's Compdata. The market shares of these other hospitals or health care systems are as follows:

	Rolling Year Ended March 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Advocate Health Care	15.6%	15.6%	15.1%
Resurrection Healthcare*	6.5%	7.2%	7.0%
Northwestern Memorial Hospital**	5.7%	5.3%	5.5%
Alexian Brothers Health System	4.4%	4.4%	4.3%
NorthShore University Health System	4.2%	4.2%	4.2%
Rush System for Health	3.9%	4.0%	4.1%
Vanguard Health Systems*	4.0%	4.0%	4.0%
Provena Health System	3.7%	3.7%	3.8%
Adventist Health System	3.2%	3.2%	3.0%
Loyola University Health System	3.0%	3.0%	2.9%

**The above table takes into account the sale of West Suburban and Westlake Hospitals by Resurrection Healthcare to Vanguard Health Systems effective August 1, 2010. Vanguard Health Systems market share includes West Suburban and Westlake Skokie Hospital across all time periods. These two hospitals are excluded from the Resurrection Healthcare totals across all times periods.*

***The above table takes into account the sale of Lake Forest Hospital to Northwestern Memorial Hospital ("NMH") which was effective February 1, 2010. NMH's market share includes Lake Forest Hospital across all time periods.*

As reflected in the table above, the Chicago metropolitan market is fragmented with the ten largest hospitals/health care systems compromising approximately 55% of the market. Over the past several years acquisition/merger activity has increased, which includes activity between existing hospitals/health systems in this market and the introduction of organizations new to this market. For example, in February, 2011, Resurrection Healthcare and Provena Health announced that they had signed a non-binding letter of intent to explore merging the two health care systems, in March 2011 Delnor Health System and Central DuPage Health announced they had merged, and in recent months, Alexian Brothers Health System and Loyola University Medical Center have announced plans to merge with separate national Catholic health care systems.

With the merger of BroMenn into Advocate in January 2010, Advocate now has a presence in the central Illinois market place. Advocate's year ended December 31, 2010 and rolling year ended March 31, 2011 market share in the thirteen counties compromising central Illinois market place based on an analysis of the Illinois Hospital Association's Compdata was 8.1% and 8.0%, respectively. In BroMenn's primary service area of McLean County, Illinois, BroMenn had a 54.1% market share for the rolling year ended March 31, 2011.

In addition to the increased hospital acquisition/merger activity affecting the markets Advocate operates in, physician group acquisitions/affiliations with the various hospitals/health care systems have increased.

Management cannot predict with any certainty whether the hospital and physician group acquisition/merger activities occurring within the market places Advocate operates will have any material adverse effect on the financial condition or operations of Advocate.

Summary of Significant Accounting Policies and Use of Estimates

Advocate's accounting policies are fundamental to understanding management's discussion and analysis of results of operations and financial condition. Many of Advocate's accounting policies require significant judgment regarding valuation of assets and liabilities and/or significant interpretation of specific accounting guidance. Advocate's significant accounting policies are described in Note 1 of Advocate's 2010 audited consolidated financial statements and are summarized in the notes to the condensed consolidated financial statements for the quarter and six months ended June 30, 2011. There have been no significant changes in accounting policies from the 2010 audited consolidated financial statements. Refer to Note Band C of notes to the condensed consolidated financial statements for the quarter and six months ended June 30, 2011 for information related to the adoption of new accounting standards and the use of estimates, respectively. Management relies on historical experience and on other assumptions believed to be reasonable under the circumstances in making its judgments and estimates. Although estimates are considered to be reasonable at the time made, actual results could differ materially from those estimates.

Financial Reporting Controls

Advocate has an established independent Audit Committee of the Board of Directors and an Internal Audit Department. The Internal Audit Department carries out an annual program of financial, operational, information technology and compliance audits that document and test internal controls over financial reporting, concentrating on accounts that require more significant judgments and estimates in the preparation of Advocate's financial statements. Advocate has adopted the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") Internal Control – Integrated Framework.

Budget Control Act of 2011

On August 3, 2011, President Obama signed the Budget Control Act of 2011 (the "Budget Control Act"). The Budget Control Act limits the federal government's discretionary spending caps at levels necessary to reduce expenditures by $917 billion from the current federal budget baseline for federal fiscal years 2011 and 2012. Medicare, Social Security, Medicaid and other entitlement programs will not be affected by the limit on discretionary spending caps.

The Budget Control Act also created a new Joint Select Committee on Deficit Reduction, which is tasked with making recommendations to further reduce the federal deficit by $1.5 trillion. Committee recommendations may include reductions in Medicare, Medicaid, Social Security and other entitlement programs. The Committee is required to report its recommendations to the Congress by a majority vote no later than November 23, 2011. The Congress is required to act on the recommendations, without amendment, by December 23, 2011. If the Committee achieves savings of between $1.2 and $1.5 trillion, the debt ceiling will be raised again by the corresponding amount.

If the Committee fails to report savings or if the Congress fails to enact them, the debt ceiling would be automatically raised by $1.2 trillion and sequestration (across the board cuts) will be triggered in an amount necessary to achieve $1.2 trillion in savings, or in the amount that an enacted committee bill fell short of $1.2 trillion. A wide range of spending, however, is exempted from sequestration, including: Social Security, Medicaid, VA benefits and pensions, federal retirement funds, civil and military pay, child nutrition, and other programs. Medicare is not exempted from sequestration. Medicare payments could be reduced in part as a result of these across the board spending reduction, limited to 2% of total program costs.

The method for achieving federal deficit reduction has been intensely debated, with significant disagreement among the Senate, the House and the President. As a result, the success of the Committee is uncertain at this time. Should the Committee fail to achieve the savings requirements discussed above, the associated cuts will have an adverse effect on the financial condition of Advocate, which could be material.

Health Care Reform Act

In March, 2010, the Health Care Reform Act was enacted. Some of the provisions of the Health Care Reform Act took effect immediately, while others will take effect or will be phased in over time, ranging from a few months following approval to ten years. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time, and minor changes to the law have already occurred in 2010 and 2011. The Health Care Reform Act will also require the promulgation of substantial implementing regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges, for a substantial period of time.

Since the enactment of the Health Care Reform Act, certain political leaders have announced their intention to proceed with legislation to repeal or amend provisions of the Health Care Reform Act. Attempts to repeal provisions of the Health Care Reform Act are pending in Congress and the constitutionality of the Health Care Reform Act is being challenged in courts around the country. The ultimate outcomes of legislative attempts to repeal or amend the Health Care Reform Act and legal challenges to the Health Care Reform Act are unknown, and may not ultimately be resolved until 2012 by the U.S. Supreme Court.

A significant component of the Health Care Reform Act is reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents and, as a consequence, expansion of the base of consumers of health care services. One of the primary drivers of the Health Care Reform Act is to provide or make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels. The Health Care Reform Act proposes to accomplish that objective through various provisions, summarized as follows: (i) the creation of active markets (referred to as exchanges) in which individuals and small employers can purchase qualified

health care insurance for themselves and their families or their employees and dependents, (ii) providing subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels, (iii) mandating that most individual consumers obtain and certain employers provide a minimum level of health care insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates, (iv) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, (v) expansion of existing public programs, including Medicaid, for individuals and families, and (vi) evaluating hospitals, physicians and other health care providers on a variety of quality and efficacy standards to support value-based payment systems. In March 2010, The Congressional Budget Office ("CBO") estimated that in federal fiscal year 2015 twenty four million consumers who are currently uninsured will become insured, followed by an additional five million consumers in federal fiscal year 2016. To the extent all or any of those provisions produce the expected result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses and/or charity care provided may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may not be offset by increased revenues.

Some provisions of the Health Care Reform Act will adversely affect some of Advocate's hospitals and other operations more significantly than others, or may not affect them at all. Moreover, the Health Care Reform Act remains subject to amendment, repeal, lack of implementation, failure to fund and judicial interpretation. The demographics of the markets in which individual hospitals and other operations of Advocate provide services, the mix of services that any hospital or other operation provide to its community and other factors that are unique to a hospital or other operation will affect operations, financial performance or financial conditions are described below. The description below of certain provisions of the Health Care Reform Act is not intended to be, nor should be considered by the reader as, comprehensive. The Health Care Reform Act is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices and laws.

Commencing upon enactment through September 30, 2019, the annual Medicare market basket updates for hospitals will be reduced. Beginning October 1, 2011, the market basket updates will be subject to productivity adjustments. The reductions in market based updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates will be effective prior to the periods during which insurance coverage and the insured consumer base will expand, which may have an interim negative effect on revenues and operating income. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in Medicare payments per discharge on a year-to-year basis.

Commencing October 1, 2010 and continuing through September 30, 2019, payments under the "Medicare Advantage" programs (Medicare managed care) have been and will continue to be restructured, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program.

The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues. Depending on performance, revenues could decrease under a value-based purchasing program.

Commencing October 1, 2012, a value-based purchasing program will be established under the Medicare program designed to provide incentive payments to hospitals based on performance on quality and efficiency measures. These incentive payments are funded through a pool of money collected from all hospital providers.

Commencing October 1, 2013, Medicare disproportionate share hospital ("DSH") payments will be reduced initially by 75%. DSH payments will be adjusted thereafter to account for the national rate of consumers who do not have health care insurance and are provided uncompensated care. Commencing October 1, 2013, a state's Medicaid DSH allotment from federal funds will also be reduced.

The Health Care Reform Act provides for the expansion of Medicaid programs to a broader population with incomes up to 138% of federal poverty levels. The CBO has estimated that sixteen million consumers who are currently uninsured will become newly eligible for Medicaid through 2019 as a result of this expansion. Providers operating in markets with large Medicaid and uninsured populations are anticipated to benefit from increased revenues resulting from increased utilization and reductions in bad debt or uncompensated care. The increase in utilization can also be expected to increase the cost of providing that care, which may or may not be balanced by increased revenues.

Commencing October 1, 2012, Medicare payments that would otherwise be made to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions will be reduced by specified percentages to account for those excess and "preventable" hospital readmissions.

Commencing October 1, 2014, Medicare payments to certain hospitals for hospital-acquired conditions will be reduced by 1%. Effective July 1, 2011, federal payments to states for Medicaid services related to health care-acquired conditions are prohibited.

Commencing October 1, 2011, health care insurers will be required to include quality improvement covenants in their contracts with hospital providers, and will be required to report their progress on such actions to the Secretary of Health and Human Services ("HHS"). Commencing January 1, 2015, health care insurers participating in the health insurance exchanges will be allowed to contract only with hospitals that have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

With varying effective dates, the Health Care Reform Act enhances the ability to detect and reduce waste, fraud, and abuse in public programs through provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The Health Care Reform Act requires the development of a database to capture and share health care provider data across federal health care programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.

Effective for tax years commencing immediately after approval of the Health Care Reform Act, additional requirements for tax-exemption are imposed upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and control the billing and collection processes. Additionally, effective for tax years commencing after March 23, 2012, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

The Health Care Reform Act provides for the establishment of an Independent Payment Advisory Board ("Payment Board") to develop proposals to improve the quality of care and limitations on cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the target the Payment Board is required to develop proposals to reduce the growth rate and require the Secretary of HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The Health Care Reform Act creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care, including bundled payments under Medicare and Medicaid, and comparative effectiveness research that studies the clinical effectiveness of medical treatments and develops and disseminates recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery programs, such as accountable care organizations or combinations of provider organizations that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

Impact of Market Turmoil

The disruption of the credit and financial markets in the last several years led to volatility in the securities markets, significant losses in investment portfolios, increased business failures and consumer and business bankruptcies, and was a major cause of the economic recession in 2008/2009. As a direct consequence, the financial condition of Advocate and its operating results were materially adversely affected.

In response to that disruption, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") was enacted on July 21, 2010. The Financial Reform Act includes broad changes to the existing financial regulatory structure, including the creation of new federal agencies to identify and respond to risks to the financial stability of the United States. Additional legislation is pending or under active consideration by Congress and regulatory action is being considered by various federal agencies and the Federal Reserve Board and foreign governments, which are intended to increase the regulation of domestic and global credit markets. The effects of the financial reform act and of these legislative, regulatory and other governmental actions, if implemented, are unclear.

The health care sector, including Advocate, was materially adversely affected by the disruption in the credit and financial markets. The consequences of these developments generally included, among other things, realized and unrealized investment portfolio losses, increased borrowing costs and periodic disruption of access to the capital markets. The economic recession adversely affected, and is continuing to adversely affect, the operations of Advocate. Patient service revenues and inpatient volumes have not increased as historic trends would otherwise indicate.

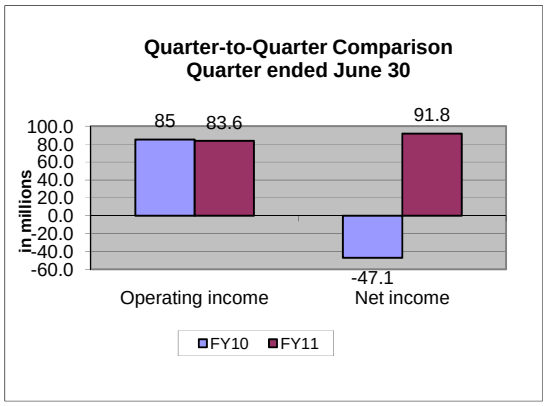
During 2008 and 2009, unemployment rates increased substantially and still remain high and in certain market areas in which Advocate owns and operates health care facilities, remains higher than the national average. Unemployment rates are higher than historic norms and in certain market areas in which Advocate owns and operates health care facilities, reduced employment and personal income have resulted in increases in self-pay admissions, increased levels of bad debt and uncompensated care, reduced demand for elective procedures, and reduced availability and affordability of health insurance.

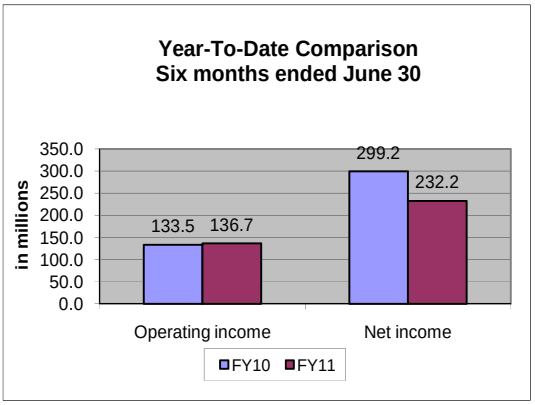
The recession is also increasing stresses on the budget of the State of Illinois in which Advocate's operations are located, resulting in delays of payment of amounts due under Medicaid and other state or local payment programs and additionally reductions in payments for services rendered to patients covered by worker's compensation insurance.

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 and a subsidy to the recently unemployed for health insurance premium costs. 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. The incentive payments will be payable annually for a period of up to four years to eligible providers that demonstrate "meaningful use" of electronic health records, assuming federal funding exists. ARRA, commencing in 2015, Medicare eligible providers that do not demonstrate "meaningful use" of electronic health records will receive a downward adjustment in federal reimbursement.

Results of Operations

Quarter-to-quarter and year-to-date comparison of payor mix and utilization information are included in Attachment 1 of this document.





Quarters Ended June 30, 2011 and 2010:

In 2008 the Center for Medicare and Medicaid Services ("CMS") approved a Medicaid assessment system scheduled to be in effect through June 30, 2014 that will result in a constant net benefit per year. For 2011 and 2010, quarterly Medicaid program revenues amounted to $36.9 million and assessment expenses were $26.6 million for a net benefit of $10.3 million

Operating income of $83.6 million was generated during the second quarter of 2011, a decrease of $1.3 million or 1.6% from the comparable period of 2010. This resulted in an operating margin of 7.1% for the quarter ended June 30, 2011 compared to an operating margin of 7.5% for the quarter ended June 30, 2010 and 7.4% for the year ended December 31, 2010.

Total revenue for the second quarter of 2011 of $1,177.9 million increased $37.8 million (3.3%) from the comparable period of the prior year. Patient service revenue of $966.1 million for the second quarter of 2011 increased $26.1 million (2.8%) from the comparable period of the prior year. The increase in patient service revenue from 2010 to 2011 was primarily the result of rate increases and an increase patient acuity partially offset by lower patient volumes and increased self-pay utilization. Capitation revenue, which amounted to $111.1 million, increased $5.5 million (5.2%) for the second quarter of 2011 compared to the second quarter of 2010 due to rate increases and an increase in membership participating in capitated plans at Advocate's affiliated physician groups.

Total expenses for the second quarter of 2011 amounted to $1,094.3 million, an increase of $39.2 million (3.7%) from the second quarter of 2010. The increase in operating expenses reflects inflationary increases and higher provision for uncollectible accounts, partially offset by focused expense management. The provision for uncollectible accounts of $55.9 million was $3.5 million higher than the second quarter 2010 due to increased self pay utilization.

Six Months Ended June 30, 2011 and 2010:

Operating income of $136.7 million was generated during the first half of 2011. This resulted in an operating margin of 6.0% compared to an operating margin of 6.0% for the six months ended June 30, 2010 and 7.4% for the year ended December 31, 2010.

Total revenue for the first half of 2011 amounted to $2,293.7 million and increased 53.2 million (2.4%) from the comparable period in 2010. Patient service revenue of $1,896.6 million for the first half of 2011 increased $45.9 million (2.5%) from the comparable period of the prior year. This increase is primarily due to rate increases and higher patient acuity, partially offset by lower patient volumes and increased self-pay utilization. Capitation revenue, which amounted to $205.6 million, increased by $1.8 million (0.9%) in 2011 compared to the first half of 2010 due primarily to rate increases and an increase in membership participating in capitated plans at Advocate's affiliated physician groups.

Total expenses for the first half of 2011 amounted to $2,157.0 million, an increase of $50.0 million (2.4%) from the first half of 2010. The increase in operating expenses reflects inflationary increases, increased patient acuity, and higher provision for uncollectible accounts partially offset by focused expense management. The provision for uncollectible accounts of $114.3 million was $7.5 million higher than the first half of 2010 due to increased self pay utilization. Insurance and claims costs of $70.3 million decreased $11.4 million (-14.0%) when compared to the first half of 2010 due to favorable claims experience.

General and Professional Liability Risks

Advocate has a comprehensive insurance program designed to conserve and protect its assets and properties. Risk transfer is utilized to shift exposures and losses to a third party indemnifier when it is deemed prudent and appropriate. Certain components of the insurance program, including hospital professional and general liability risks, are self-insured on a claims-made basis. Advocate purchases excess liability insurance in amounts it deems necessary to cover losses that may exceed its self-insured portion. Limits of excess liability insurance are commensurate with health care industry standards and are placed with insurance carriers that are currently financially sound.

Actuarial consultants are retained to determine funding requirements as well as to assist in the estimation of outstanding general and professional liabilities for retained risks. Accruals for general and professional liability claims are actuarially determined on a discounted basis (utilizing a 4.0% rate as of and for the six months ended June 30, 2011 and year ended December 31, 2010, respectively). The estimated cost of claims is actuarially determined based on past experience as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance and claims costs would have been approximately $62.8 million greater at December 31, 2010 had these liabilities not been discounted. Advocate targets to fund its self-insured general and professional liabilities, on a claims-made basis, at the discounted, expected range into an irrevocable trust that is administered by a bank trustee and a captive insurance company.

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts.

Advocate maintains commercial insurance policies for additional lines of coverage relevant to the operation of an integrated health care delivery system. Some policies carry deductibles. All coverages, insurance placement lines and self-insured programs are reviewed annually by an independent insurance auditor.

Effective January 1, 2002 Advocate became self-insured for hospital general and professional liability claims up to $15.0 million per occurrence. Beginning January 1, 2008, the retention on self insured general and professional liability claims was reduced to $12.5 million per occurrence. BroMenn and Eureka self-insured retention levels have been established at $3.0 million. Excess insurance policies are in place above the self-insurance retention for the hospitals. Management anticipates that general and professional liability insurance and claims costs will increase.

Professional liability insurance policies (underlying and excess coverage) related to Advocate's employed physicians expired on September 30, 2002. The insurance company at that time, MIIX Insurance Companies of New Jersey ("MIIX") is currently in a voluntary run off of claims and has ceased underwriting new policies. Advocate acquired underlying claims made policies for the years ended September 30, 2003 and 2004 with ISMIE Mutual; however excess coverage was not available. Underlying insurance coverage for the majority of physicians employed was written through a wholly-owned captive insurance company of Advocate effective July 1, 2004. Actuarial calculations of estimated losses above the underlying policy limits have been made by consulting actuaries and incorporated into financial results from July 1, 2002 forward.

Prior to July 1, 2004, the wholly-owned captive insurance company only issued excess general and professional liability policies, which were all reinsured, for Advocate's hospital insurance program. In December 2004 this captive began providing general and professional liability coverage to an affiliated medical group managed by Advocate.

Independent physicians that are credentialed to be a member of an Advocate hospital medical staff must maintain specified insurance levels to practice. Costs of general and professional liability claims can make it difficult for physicians to maintain such coverage. These market forces may exert further upward pressure on Advocate's insurance expense and/or affect its relations with medical staff members.

Advocate is a defendant in certain litigation related to professional and general liability risks. Although the outcome of the litigation cannot be determined with certainty, Management believes, after consultation with legal counsel, that the ultimate resolution of this litigation will not have any material adverse effect on Advocate's operations or financial condition.

In August 2005 the State of Illinois enacted a law that provided for several critical medical liability reforms, including caps on non-economic damages at $0.5 million per physician per claim and $1.0 million per hospital per claim and structured awards to more efficiently provide for future medical care for injured plaintiffs. On February 4, 2010, the Illinois Supreme Court ruled that limits on damages in medical malpractice cases are unconstitutional. This was the third time the Illinois Supreme Court has ruled that cap liability award laws were unconstitutional. With the overturn of the Illinois Tort Reform statute, the frequency of claim filings has been increasing. At this time, management is uncertain whether there will be additional efforts to cap non-economic damages, and accordingly, management cannot predict whether the Illinois Supreme Court decision will have a material impact on future insurance and claims cost expense.

Liquidity and Capital Resources

Unrestricted cash and investment balances (including amounts reported as part of assets limited to use, amounts held in trust under debt agreements and investments under securities lending program) was $3,015.6 million at June 30, 2011 and $2,921.6 million at December 31, 2010. Attachment 2 provides a summary of available liquidity at June 30, 2011.

Cash utilized by operating activities during the first half of 2011 amounted to $144.5 million compared to $60.6 million of cash provided during the first half of 2010, a decrease of $201.8 million. Compared to the first half of 2010, the decrease in cash provided by operating activities was primarily related to an increase in investment return, increase in marketable investments, and patient accounts receivable primarily reflecting slower processing of Medicaid payments by the State of Illinois.

Day's cash and investments on hand were 272 as of June 30, 2011, a decrease of 1 day from December 31, 2010. The decrease is primarily attributed to an increase in average daily operating expenses and capital spending.

At June 30, 2011 Advocate had lines of credit with banks aggregating to $200.0 million. These lines of credit provide for various interest rates, payment terms and expire as follows, $50.0 million in December 2011, $25.0 million in March 2012, $75.0 million in March 2013 and $50.0 million in November 2013. These lines of credit may be used to redeem bonded indebtedness, pay costs related to such redemptions, for capital expenditures or for general working capital purposes. At June 30, 2011 and December 31, 2010 no amounts were outstanding on these lines of credit.

Net capital expenditures amounted to $64.6 million and $46.5 million for the quarters ended June 30, 2011 and 2010, respectively; $123.0 million and $70.7 million for the six months ended June 30, 2011 and 2010, respectively; and $178.7 for the year ended December 31, 2010. The increase in capital expenditures in 2011 compared to 2010 primarily reflects Management's decision in 2009 and early 2010 to reduce capital spending to mitigate the impact of the economic recession and market turmoil, and expenditures made in 2011 towards two bed tower projects on hospital campuses. Capital spending in 2010 and 2011 was made from cash generated from operations, existing investment balances and proceeds from the 2010 bond issuance.

In May, 2011, management requested from Advocate's Board of Directors, authorization for approximately $475.0 million of new capital projects. These capital expenditures include various infrastructure improvement, clinical technology and information technology projects and will be funded by unrestricted cash and investments and additional borrowings in the amount of $200.0 million. Management received authorization for this borrowing from its Board of Directors in May 2011 and the Illinois Finance Authority in July 2011.

Advocate is party to a standby bond purchase agreement ("SBPA") with three banks to provide liquidity support in the event of a failed remarketing of the Series 2008C Bonds, other than the $22.0 million Series 2008 C-3B bonds, which were converted to long-term rate bonds in 2009. The SBPA requires various reporting, operating and financial covenants to be maintained. Unless extended, the SBPA terminates on August 20, 2013. In the event that any unreimbursed liquidity draws ("Bank Bonds") are outstanding on the termination date of the SBPA, such Bank Bonds will be subject to mandatory redemption or mandatory purchase and will amortize over five years in twenty equal quarterly installments of principal plus interest, with the initial installment commencing three months after the termination date of the SBPA. At June 30, 2011, December 31, 2010 and the date of this report there were no Bank Bonds outstanding.

The Series 2008A-1, A-2 and A-3 Bonds, issued in 2008, and the Series 2003A and C Bonds, issued 2003, were issued as uninsured variable rate demand bonds with stated repayment installments through 2030. On February 1, 2011, the outstanding Series 2008A-2 Bonds ($43.2 million) were remarketed for a new two year interest rate period. On February 10, 2011, the outstanding Series 2008A-1 Bonds ($51.1 million) were successfully remarketed for a new approximate one year interest rate period. On March 25, 2011, the outstanding Series 2003C Bonds ($27.7 million) were successfully remarketed for a new approximate one year interest rate period.

Certain of Advocate's outstanding uninsured variable rate bonds bear interest at long term rates for a particular interest rate period, and are subject to mandatory tender at the end of each particular interest rate period. The following table summarizes the next scheduled mandatory tender dates for these bonds as of the date of this document. In the event these bonds are not remarketed upon mandatory tender at the end of their current interest rate period, management anticipates utilizing marketable unrestricted investments and/or available lines of credit to meet the obligations.

Series	Principal Amount	Next Mandatory Tender Date
Series 2008A-1	$51.1 million	February 1, 2012
Series 2003C	$27.7 million	March 28, 2012
Series 2008A-3	$51.1 million	May 1, 2012
Series 2008A-2	$43.2 million	February 1, 2013
Series 2003A	$28.4 million	July 1, 2014
Series 2008C-3B	$22.0 million	July 1, 2014

The Series 2008A-1, 2008A-3, and 2003C Bonds are classified as current liabilities in the condensed consolidated balance sheets due to the fact that these bonds are subject to mandatory tender within twelve months of the June 30, 2011 balance sheet date.

Under regulatory rules of the State of Illinois, Advocate is required to post a letter of credit with a State agency to operate a self-insured workers' compensation program. At June 30, 2011 and December 31, 2010, the amount of the letter of credit outstanding totaled $15.9 million and $13.9 million, respectively. A separate letter of credit related to the Condell self-insured workers' compensation program was outstanding at June 30, 2011 and December 31, 2010 in the amount of $1.0 million. Additionally, in 2004 Advocate established a letter of credit in connection with a building lease arrangement which was outstanding in the amount of $3.1 million at June 30, 2011 and December 31, 2010. No amounts were drawn on these letters of credit as of June 30, 2011 or December 31, 2010.

Management believes that Advocate's financial condition is generally good. Advocate's cash, other liquid assets, operating cash flow, borrowing capacity and ability to lease certain medical equipment, taken together are believed to provide adequate resources to fund ongoing operating requirements and maintenance capital requirements.

Investment Program

Advocate's investment program is strategically structured to maximize long term growth over a full market cycle through a meaningful commitment to equities and fixed income investments. Advocate's Board of Directors has adopted an investment policy (which is reviewed on an annual basis and amended periodically) that regulates the allocation of substantially all of Advocate's investment assets and further defines investment vehicles utilized among other guidelines. The policy was last revised in November 2010. The allocation of assets in the investment portfolio reflects the capital and working capital requirements, earning power, debt structure of Advocate and the projected investment market environment.

Advocate's asset allocation provides for a commitment to equity securities (30.0%), fixed income investments (35.0%), select alternative investment classes (25.0%) and cash and cash equivalents (10.0%). For each of the above categories the policy establishes allocation targets among the following investment styles: 10.0% large and mid capitalization equity (enhanced index, value and growth); 5.0% non-large capitalization equities (value and growth); 10.0% international equities; 5.0% emerging markets; 17.5% core plus bonds; 7.5% intermediate bonds; 10.0% U.S. Treasury inflation protected securities; 10.0% private equity; 10.0% hedge funds; 5.0% real assets, and 10.0% cash equivalents. Additionally, there are specific ranges for each asset class. Further, limitations are placed on investment managers as to the overall amount that can be invested in one issuer (except for U.S. government obligations and its agencies) or economic sector. Assets of the program will continue to be managed by a number of external investment professionals. Further, Advocate utilizes the services of an independent investment consultant to assist in the evaluation of the performance of investment managers and the total portfolio.

At June 30, 2011, Advocate had approximately 35% of its assets invested in equities, 33% in fixed income securities, 17% in hedge funds and private equity limited partnerships and real assets, and 15% in cash equivalents. At June 30, 2011, Advocate is committed to fund $199.0 million to various private equity limited partnerships over the next six years. The overall yields (not annualized) on Advocate's investment portfolio for the quarters ended June 30, 2011 and 2010 were 1.0% and -2.4%, respectively, for the six months ended June 30, 2011 and 2010 were 3.8% and 0.7%, respectively; and for the year ended December 31, 2010 was 10.5%.

Management continues rebalancing the portfolio to bring it in line with the allocation targets established in November 2010. Depending on the investment style and market conditions this rebalancing is anticipated to take several years.

Managed Care and Capitation Revenue

Managed Care payors accounted for approximately 37% of hospital admissions and 54% of net patient service revenue for the six months ended June 30, 2011. Given the challenges faced in the managed care marketplace, Advocate continues to attempt to secure reasonable reimbursement rates. In the first quarter of 2011, Advocate finalized a new three-year contract ending December 31, 2013 with a significant payor, Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois ("Blue Cross"), which represented approximately 26% of Advocate's net patient service revenue for the six months ended June 30, 2011.

Since June 1998, Advocate has been party to a capitated physician provider agreement with Humana Health Plan, Inc. and Humana Insurance Company and their affiliates ("Humana"). Management finalized the renewal for the commercial (through December 31, 2011) and Medicare (through December 31, 2011) HMO products of this capitated agreement with one of Advocate's wholly owned medical groups, and also Advocate's hospital agreements with Humana (through December 31, 2011). These agreements will automatically renew for one-year terms unless either party provides a notice of termination. Capitation revenue received under the commercial and Medicare HMO agreements with Humana amounted to 39% and 37% of total capitation revenue for the quarters ended June 30, 2011 and 2010, respectively; 39% and 37% for the six months ended June 30, 2011 and 2010, respectively; and 37% for the year ended December 31, 2010.

Contracts with other managed care payors are generally no more than two years in length and subject to automatic renewal, renegotiation or termination at end of term. Negotiations related to contract renewals can be acrimonious and such contracts may or may not be renewed. Advocate cannot predict with any certainty the ultimate outcome of future negotiations with managed care payors as contracts expire. As of the date of this document, there are no other managed care contracts under termination notice.

Management anticipates that the Health Care Reform Act will substantially alter the commercial health care insurance industry -see above in Health Care Reform Act section for additional information.

Guarantees of Debt, Swaps and Other Derivatives and Financing Arrangements

Interest Rate Swaps:

As described in Note H, in connection with the issuance of certain bonds in 2005 and 2007, Advocate entered into multiple floating-to-fixed interest rate swap arrangements (collectively, the "Citi Swaps") with Citibank, N.A. New York ("Citi") pursuant to an ISDA Master Agreement. All Citi and System payments are made on a same day net payment basis with reference to a notional amount that declines over the term of the Citi Swaps. Unless terminated earlier, in accordance with their terms, the Series 2008C Swaps will terminate on November 1, 2038. Under certain circumstances, however, the Citi Swaps are subject to termination prior to the scheduled termination date.

See Note G – Fair Value Measurements and Note H – Derivatives to the Condensed Consolidated Financial Statements for the fair value and a description of the accounting treatment of Advocate's swap arrangements.

Debt Guarantees:

Advocate has agreed to provide a $1.0 million advance to a third-party under the terms of a management service organization agreement. No amounts have been advanced under this arrangement.

In connection with Advocate's ownership interest in RML Health Providers L.P. ("RML"), Advocate has agreed to guarantee $1.2 million of RML's outstanding debt.

Securities Lending:

As part of the management of the investment portfolio, Advocate has entered into an arrangement whereby securities owned by Advocate are loaned, primarily to brokers and investment bankers. The loans are arranged through a bank. Borrowers are required to post collateral in the form of cash or United States Treasury securities for securities borrowed equal to approximately 102% of the value of the security loaned on a daily basis. The bank is responsible for reviewing the credit-worthiness of the borrowers. Advocate has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At June 30, 2011, Advocate loaned approximately $18.1 million in securities and accepted collateral for these loans in the amount of $18.5 million of which $18.2 million represented cash collateral. The cash collateral received under the securities lending program has been reflected as a current asset and a current obligation payable in the condensed consolidated balance sheets presented.

Acquisitions and Divestitures

Advocate, from time to time, engages in dialogue with a variety of organizations about options that might allow Advocate to further its mission of meeting the health care needs of the communities it serves, or expand Advocate's mission into new communities.

On June 30, 2011, Advocate and Midwest Heart Specialists ("MHS") the largest independent cardiology practice in Illinois with 50 physicians signed a letter of intent to integrate with Advocate. MHS, headquartered in Oak Brook, IL, has been providing cardiac services throughout the Chicago metropolitan area and Rockford, IL, since 1973. In addition to earning numerous physician accolades, MHS has been nationally recognized for its quality data and early adoption of electronic medical records. The transaction is expected to be completed by the end of this year, subject to the completion of due diligence, execution of a definitive agreement, regulatory and other approvals.

There were no other significant acquisitions or divestitures completed during the six months ended June 30, 2011 and through the date of this document.

Commitments

Advocate has various commitments to construct additions and renovations to its medical facilities and future minimum rental commitments under the terms of non-cancellable leases. These obligations are described in Note 11 to the consolidated financial statements, together with the report of the independent auditors, as of and for the years ended December 31, 2010 and 2009.

Executive Management

In March, 2011, Jerry Wagenknecht, Senior Vice President, Mission and Spiritual Care, announced his plan to retire in June, 2011. In July 2011, Kathie Bender Schwich was appointed Senior Vice President, Mission and Spiritual Care. There were no other changes in executive management during the six months of 2011 and through the date of this document.

Ratings

Moody's Investors Services, Inc. ("Moody's"), Standard and Poor's Rating Services ("S&P") and Fitch Ratings ("Fitch") have assigned long-term ratings of Aa2, AA and AA, respectively, to the long-term debt of Advocate. There were no changes to Advocate's assigned long-term ratings during the first six months of 2011 and through the date of this document.

In connection with various bond issues Advocate has obtained short-term credit ratings from each of the three rating agencies. Moody's S&P and Fitch have assigned short-term ratings of Aa2/VMIG1, A-1+ and F1+, respectively. There were no changes to Advocate's assigned short-term ratings during the first six months of 2011 and through the date of this document.

The aforementioned ratings reflect only the view of the rating agency providing the same and an explanation of the significance of such ratings may be obtained only from the rating agency furnishing the same. Certain information and materials not included in this unaudited quarterly report may have been furnished to the rating agencies. Generally, rating agencies base their ratings on the information and materials so furnished and on investigations, studies and assumptions performed or made by the rating agencies. There is no assurance that the ratings will continue for any given period of time or that these ratings will not be revised downward or withdrawn entirely by any of such rating agencies if, in the judgment of such rating agency, circumstances so warrant. Any downward revision or withdrawal of such ratings may have a material adverse effect on the market price of Advocate's outstanding tax exempt bonds.

Laws, Regulations and Related Litigation

As a health care provider, Advocate and its subsidiaries are subject to extensive and frequently changing federal, state and local laws and regulations governing various aspects of our business. In particular, Advocate and its subsidiaries provide a broad range of services, many of which are regulated by different government agencies, subject to differing regulatory schemes and subject to contractual reviews and program audits in the normal course of business. Many operations that Advocate and its subsidiaries undertake are subject to significant governmental certification and licensing regulations, as well as federal and state laws, including those relating to:

fraud and abuse;
billing and pricing practices;
kickbacks, referrals, rebates and fee-splitting;
antitrust;
tax-exempt status, including intermediate sanctions;
tax-exempt financing including the use of bond proceeds;
marketing, sales, and pricing practices;
privacy and security of personal medical information;
human subject research;
the handling and disposal of medical specimens, hazardous waste and controlled substances;
occupational safety; and consumer protection.

Government agencies and private whistleblowers have made enforcement of the provisions relating to false claims, kickbacks, physician self-referral and various other fraud and abuse laws a major priority in recent years. Potential sanctions for violation of these statutes and regulations include significant fines and criminal penalties and the loss of various licenses, certificates and authorizations, and loss of tax-exempt status.

The Recovery Audit Contractor Program ("RAC Program") is a Center for Medicare and Medicaid ("CMS") program that was part of the Medicare Modernization Act of 2003 on a pilot basis and then made permanent in the Tax Relief and Healthcare Act of 2006. The Health Care Reform Act expanded the RAC Program to include the Medicaid program. The goal of the RAC Program is to identify and correct improper payments made to providers. RAC Program activities are executed by contractors selected by CMS, who are compensated on a contingency basis. Contractors have three years from the time a claim is paid to review that claim. However no claims paid prior to October 2007 can be reviewed. RAC Program activity in Illinois commenced in February 2010. Advocate has prepared for the RAC Program by, among other things, forming a system-wide regulatory response task force to track, address and coordinate responses to various RAC Program activities at Advocate's sites. Management cannot predict whether the RAC Program will have a material impact on the results of operations and financial condition of Advocate.

The Civil Division of the Department of Justice ("DOJ") has contacted Advocate in connection with the DOJ's nationwide review of whether, in certain cases, hospital charges to the federal government relating to implantable cardio-defibrillators ("ICDs") met the Centers for Medicare & Medicaid Services criteria. In connection with this nationwide review, the DOJ has indicated that it will be reviewing certain ICD billing and medical records at certain of Advocate's hospitals for the period from October 2003 to the present. The review could potentially give rise to claims against Advocate under the federal false claims act or other statutes, regulations or laws. At this time, Management cannot predict what effect, if any, this review or any resulting claims could have on Advocate.

The Health Care Reform Act has made several changes to the Medicare program, ranging from changes to amounts payable to providers through imposition, directly or indirectly, of quality assurance measures. Those changes are summarized above under the caption, "Health Care Reform Act." The Health Care Reform Act also amended certain provisions of the Federal False Claims Act and added provisions respecting the timing of the obligation to reimburse overpayments. Further, the Health Care Reform Act authorizes the Secretary of Health and Human Services to exclude a provider's participation in the Medicare, Medicaid and CHIP programs as well as to suspend payments to a provider pending an investigation of a credible allegation of fraud against the provider.

Advocate expects that the level of review and audit to which it and other health care providers are subject will increase. To foster compliance with applicable laws, Advocate has a compliance program that is designed to detect and correct potential violations of laws and regulations related to its programs. Advocate also tracks enforcement trends, closely reviews government advisories concerning suspect practices, and regularly undertakes to educate its officers, associates and vendors concerning applicable laws and regulations. However, many of the laws and regulations affecting Advocate and its subsidiaries have not been interpreted by regulators or the courts or have been subject to varying interpretations. As a result, regulators may contend that they have broad authority to assert claims for noncompliance and assert claims or penalties based upon their interpretation of those requirements. It is not possible to determine the impact, if any, such claims or penalties would have upon Advocate and its subsidiaries.

Billing Practices for Uninsured and Under-Insured Patients

Both federal and state authorities have opened investigations into the health care industry's billing practices for uninsured and under-insured patients. Billing and charge practices of hospitals continue to be subject to the intense scrutiny of federal, state and local governmental agencies.

Billing and collection practices and procedures are governed by a detailed and complex array of federal Medicare statutes, regulations and policy pronouncements. Advocate believes that its billing and collection practices are consistent with federal and state policies and regulations and intends to vigorously defend its practices if challenged.

Management of Advocate believes that its billing and collection practices comply with current law, though as indicated in the section above entitled "Laws, Regulations and Related Litigation", laws and regulations related to billing practices have not been interpreted by the courts or regulators or have been subject to varying interpretations.

As a faith-based health care organization, the mission, values and philosophy of Advocate form the foundation for its strategic plan. Advocate's mission is to serve the health care needs of individuals, families and communities through a wholistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. The number of uninsured and under-insured individuals is a national issue and the State of Illinois has a significant number of uninsured and under-insured individuals in the nation. Families with income levels of up to six hundred percent of the federal poverty level are eligible for free or discounted care. Additionally, Advocate does not place liens on primary residences and considers employment status and financial resources of insured and uninsured patients before taking legal action in its accounts receivable collection efforts. As community needs evolve Advocate periodically reviews and revises its policies and procedures relating to charity care.

Tax-Exempt Status

Due to budget deficits and declining tax revenues and the growing numbers of un- and underinsured in the United States, federal, state and local governments are increasingly scrutinizing the tax status of not-for-profit hospitals. Over the past several years, various hearings and studies have been undertaken by the federal government related to the tax status of entities exempt from Federal Income Tax under Section 501(c)(3) of the Internal Revenue Code. Some of these hearings and studies were designed to address the question of equating tax exempt status with community benefits provided. Other issues addressed included executive compensation levels and corporate compliance. Management cannot predict whether these hearings or studies will ultimately lead to new or changed legislation or regulations that will affect Advocate's tax exempt status.

Real estate property tax and sales tax exemptions for not-for-profit hospitals in the State of Illinois have been questioned and challenged both at the State and local levels. The ultimate outcome of these questions and challenges cannot be predicted however the exemptions currently enjoyed by not-for-profit hospitals may be at risk. Illinois law requires hospitals to use its properties for charitable purposes to qualify for tax exemption. On March 18, 2010, The Illinois Supreme Court ruled in favor of the Illinois Department of Revenue ("IDOR") in a nationally closely watched case involving the property-tax exemption of Provena Covenant Medical Center, Champaign, IL ("Provena"). One of the factors in determining whether a property is used for charitable purposes is an organizations provision of charity care. In its decision, the Illinois Supreme Court agreed with an appellate court decision that Provena's provision of charity care was inadequate to demonstrate that Provena was using its property for a charitable purpose. The impact of this decision, both in Illinois and nationally, will be closely watched by hospitals and policymakers. IDOR has since 2004 denied property tax exemption requests in several applications impacting other Illinois healthcare providers. The most recent denials were announced during the week of August 8, 2011, which affects property parcels owned by three other acute care/ women's hospitals, two of which are located in the Chicagoland area. Management cannot predict whether the Provena decision will have an impact on any of its current tax exempt properties, or any properties obtained as a result of future purchases, gifts, or business combinations.

On November 4, 2010, Advocate received from the IDOR a request for additional information related to an application for property tax exemption on Advocate Condell Medical Center which was tax exempt prior to its acquisition by Advocate. The request seeks various documents and information, including information related to the hospital's charity care policy and provision of charity care. Management cannot predict the outcome of this property tax exemption request. Management does not believe that an adverse determination regarding the tax-exempt status of this property will have a materially adverse effect on the financial condition of results of operation of Advocate.

Under Illinois law, organizations exempt from sales and use tax must request renewal of their exemption every five years. Advocate Health and Hospitals Corporation ("AHHC") and Advocate Charitable Foundation ("ACF") applied for renewal of their exemptions, and on April 15, and May 12, 2011, respectively, both received a letter from IDOR indicating that their applications are under review. In these letters, IDOR indicated that AHHC and ACF can continue to operate under their current exemptions until a final determination is made. IDOR indicted in these letters that it is still developing a strategy to handle both pending property tax applications and sales and use exemption applications and renewals. IDOR did indicate in this letter that exemption will likely be made on a case by case basis on each organization's merits. IDOR has not indicated a time table for when it will be making determinations.

Management cannot predict the outcome of the aforementioned property tax exemption and sales tax exemption renewal requests, or with any certainty, the impact on the financial condition or results of operation of Advocate if an adverse ruling(s) is received.

As set forth elsewhere in this report, a variety of Advocate's practices are under examination by a number of governmental agencies and private parties. Moreover, some commentators have suggested that the recently-enacted Health Care Reform Act (see discussion above) will result in additional scrutiny of tax-exempt health care providers, including expanding the requirements for maintenance of Section 501(c)(3) status by hospitals to include maintenance and monitoring of charity care policies and procedures.

Although no government entity has yet challenged Advocate's tax-exempt status, the increased government scrutiny could lead federal, state or local agencies to challenge Advocate's tax-exempt status.

Corporate Compliance

Advocate has established a Business Conduct (Compliance) Program intended to assist Advocate Board members, associates, physicians and vendors to conform their actions to comply with the numerous laws and regulations applicable to the healthcare industry. As part of this program, Advocate has developed and implemented Business Conduct Guidelines, a Conflict of Interest Policy and a Code of Business Conduct to describe such laws and regulations and give clear guidance as to the manner in which Advocate associates are to conduct their day to day activities. The program is overseen by the Vice President of Corporate Compliance, who reports functionally and administratively to Advocate's Senior Vice President and General Counsel as well as functionally to the President and Chief Executive Officer, Executive Management Team and Advocate Business Conduct Committee. Each major site within Advocate has established a Site Business Conduct Committee in an effort to ensure that it is implementing the Business Conduct Program into its operations. The business conduct program is primarily concerned with the following areas: patient care, confidentiality, information privacy, information systems security, discrimination, harassment, safety and health, conflicts of interest, tax exemption principals, Medicare/Medicaid fraud and abuse laws, Stark anti-referral legislation, and Medicare and Medicaid coding and billing procedures. In addition, a Business Conduct Hot Line provides associates with an anonymous means to report violations of the program or seek guidance and clarification on issues or concerns they might have with respect to their own conduct or the conduct of other Advocate associates. Advocate has educated its board, associates, physicians and vendors as to the elements of the program. The Business Conduct (Compliance) Program undergoes periodic review and updates based on new developments.

Dates of the Condensed Consolidated Financial Statements and Management Discussion and Analysis of Financial Condition and Results of Operations

The condensed consolidated financial statements and the sources of system net patient service revenue, utilization statistics and ratios (attachment 1) and liquidity worksheet (Attachment 2) were prepared as of July 15, 2011. The management discussion and analysis of financial condition and results of operations were prepared as of August 26, 2011.

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Sources of System Net Patient Service Revenue, Utilization Statistics and Ratios

	For the quarter ended June 30,		For the six months ended June 30,		For the Year ended December 31,
	2011	2010	2011	2010	2010
SOURCES OF SYSTEM NET PATIENT SERVICE REVENUE					
Medicare	26 %	26 %	26 %	26 %	26 %
Medicaid	10	10	10	11	11
Managed Care	54	52	54	53	53
Self pay, and other	10	12	10	10	10
	100 %	100 %	100 %	100 %	100 %
UTILIZATION STATISTICS					
Acute Care Hospitals:					
Admissions	41,910	42,713	83,769	85,362	170,254
Average Length of Stay (days)	4.47	4.44	4.54	4.50	4.52
Observation Cases	9,817	9,276	19,160	18,851	37,162
Outpatient Visits	405,946	423,050	813,236	847,854	1,681,953
Home Health					
Home Health Care Admissions	5,050	4,435	9,974	8,960	18,445
Physician Practices					
Covered Lives					
Full Risk	25,183	26,304	25,183	26,304	25,745
Partial Risk	95,964	93,665	95,964	93,665	91,341
FINANCIAL RATIOS					
Operating Margin	7.1%	7.5%	6.0%	6.0%	7.4%
Net Margin	7.7%	-4.7%	9.7%	3.4%	17.1%
Operating Cash Flow Margin	11.6%	12.1%	10.6%	10.7%	12.1%
EBITDA Margin	14.4%	0.8%	14.2%	8.3%	21.8%
OTHER FINANCIAL INDICATORS					
Days Cash on Hand (a)			272	228	273
Debt Service Coverage (b)			10.1x	8.4x	10.1x
Debt to Capitalization Ratio (b)			22.3%	27.4%	23.5%
Cash to Debt			294.2%	233.9%	280.8%

(a) The days cash on hand calculation for June 30, 2011, June 30, 2010 and December 31, 2010 excludes the Medicaid assessment payable / expense as such amounts are not payable until the additional Medicaid revenue is received.

(b) Calculated as required by the terms of the Master Trust Indenture (Amended and Restated).

The Sources of System Net Patient Service Revenue, Utilization Statistics and Ratios were prepared as of July 15, 2011

Attachment 2

Advocate Health Care Network and Subsidiaries
Liquidity Worksheet Summary as of June 30, 2011

ASSETS (Gross) $ in Thousands		
Daily Liquidity		
Money Market Funds (Moody's rated Aaa)	$27,749	
Operating Cash	327,803	
US Treasuries & Aaa-rated Agencies (<3 year maturity)	54,451	
US Treasuries & Aaa-rated Agencies (>3 year maturity)	26,489	
Subtotal Daily Liquidity (Cash & Securities)		**$436,492**
General Purpose Line of Credit		200,000
Subtotal Daily Liquidity		636,492
Weekly Liquidity		
Publicly Traded Fixed Income Securities (Aa3 or higher) and P-1 Commercial Paper	981,237	
Exchange Traded Equities (Stock and Mutual Funds)	978,046	
Subtotal Weekly Liquidity		1,959,283
TOTAL DAILY AND WEEKLY LIQUIDITY		**$2,595,775**
Monthly Liquidity		
Funds, vehicles, investments that allow withdrawals with one month notice or less		117,179
Longer-Term Liquidity		
Funds, vehicles, investments that allow withdrawals with greater than one month notice (Hedge & Private Equity)		502,617
LIABILITIES (Self-Liquidity Debt Shorter than 13 Months)		
Scheduled Mandatory Tender VRDBs Within 13 months		
Mandatory tenders scheduled on: 02/01/2012	51,140	
Mandatory tenders scheduled on: 03/28/2012	27,695	
Mandatory tenders scheduled on: 05/01/2012	51,145	
Subtotal Other Liabilities		129,980
TOTAL LIABILITIES (Self-Liquidity Debt Shorter Than 13 months)		**$129,980**

The Liquidity Worksheet was prepared on July 15, 2011.