Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended September 30, 2016

The Cleveland Clinic Foundation
d.b.a. Cleveland Clinic Health System

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	September 30 2016	December 31 2015
Assets		
Current assets:		
Cash and cash equivalents	$ 415,872	$ 249,580
Patient receivables, net	1,058,151	950,304
Investments for current use	52,223	53,852
Other current assets	379,591	408,139
Total current assets	1,905,837	1,661,875
Investments:		
Long-term investments	6,373,251	6,184,378
Funds held by trustees	148,431	125,723
Assets held for self-insurance	117,619	93,662
Donor restricted assets	604,580	565,161
	7,243,881	6,968,924
Property, plant, and equipment, net	4,439,190	4,388,667
Other assets:		
Pledges receivable, net	142,337	141,468
Trusts and interests in foundations	82,750	86,741
Other noncurrent assets	390,144	353,748
	615,231	581,957
Total assets	$ 14,204,139	$ 13,601,423

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	September 30 2016	December 31 2015
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 374,859	$ 412,559
Compensation and amounts withheld from payroll	362,445	295,668
Current portion of long-term debt	240,051	95,694
Variable rate debt classified as current	457,885	520,960
Other current liabilities	452,987	467,042
Total current liabilities	1,888,227	1,791,923
Long-term debt:		
Hospital revenue bonds	2,909,665	2,725,760
Notes payable and capital leases	458,104	466,020
	3,367,769	3,191,780
Other liabilities:		
Professional and general insurance liability reserves	161,010	139,617
Accrued retirement benefits	368,585	490,753
Other noncurrent liabilities	520,456	478,352
	1,050,051	1,108,722
Total liabilities	6,306,047	6,092,425
Net assets:		
Unrestricted	6,987,798	6,627,406
Temporarily restricted	607,592	586,276
Permanently restricted	302,702	295,316
Total net assets	7,898,092	7,508,998
Total liabilities and net assets	$ 14,204,139	$ 13,601,423

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended September 30	
	2016	2015
Unrestricted revenues		
Net patient service revenue	$1,881,773	$1,670,777
Provision for uncollectible accounts	(78,483)	(58,596)
Net patient service revenue less provision for uncollectible accounts	1,803,290	1,612,181
Other	202,630	158,686
Total unrestricted revenues	2,005,920	1,770,867
Expenses		
Salaries, wages, and benefits	1,105,155	925,790
Supplies	185,428	162,516
Pharmaceuticals	221,182	179,898
Purchased services and other fees	131,013	101,528
Administrative services	48,437	49,117
Facilities	81,798	77,464
Insurance	15,869	14,731
	1,788,882	1,511,044
Operating income before interest, depreciation, and amortization expenses	217,038	259,823
Interest	34,759	30,989
Depreciation and amortization	120,209	100,851
Operating income before special charges	62,070	127,983
Special charges	3,650	-
Operating income	58,420	127,983
Nonoperating gains and losses		
Investment return	232,906	(277,968)
Derivative losses	(2,822)	(28,849)
Other, net	(870)	(342)
Net nonoperating gains and losses	229,214	(307,159)
Excess of revenues over expenses	287,634	(179,176)

Unaudited Consolidated Statements of Operations and Changes in Net Assets (continued)

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Total net assets at July 1, 2015	$ 6,343,908	$ 539,685	$ 289,856	$ 7,173,449
Deficiency of revenues over expenses	(179,176)	-	-	(179,176)
Donated capital and assets released from restrictions for capital purposes	2,044	(2,044)	-	-
Gifts and bequests	-	34,372	11,854	46,226
Transfer of net assets	(176)	176	-	-
Net investment loss	-	(16,842)	-	(16,842)
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(7,727)	-	(7,727)
Retirement benefits adjustment	(757)	-	-	(757)
Change in interests in foundations	-	(1,533)	-	(1,533)
Change in value of perpetual trusts	-	-	(414)	(414)
Net change in unrealized losses on nontrading investments	(2,557)	-	-	(2,557)
Other	(337)	-	-	(337)
(Decrease) increase in net assets	(180,959)	6,402	11,440	(163,117)
Total net assets at September 30, 2015	$ 6,162,949	$ 546,087	$ 301,296	$ 7,010,332
Total net assets at July 1, 2016	$ 6,738,530	$ 593,552	$ 298,525	$ 7,630,607
Excess of revenues over expenses	287,634	-	-	287,634
Donated capital and assets released from restrictions for capital purposes	2,664	(2,592)	-	72
Gifts and bequests	-	10,659	6,306	16,965
Transfer of net assets	(1,997)	1,997	-	-
Net investment income	-	13,920	-	13,920
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(10,641)	-	(10,641)
Retirement benefits adjustment	(555)	-	-	(555)
Change in interests in foundations	-	697	-	697
Change in value of perpetual trusts	-	-	(2,129)	(2,129)
Net change in unrealized gains on nontrading investments	52	-	-	52
Other	(38,530)	-	-	(38,530)
Increase in net assets	249,268	14,040	4,177	267,485
Total net assets at September 30, 2016	$ 6,987,798	$ 607,592	$ 302,702	$ 7,898,092

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets (continued)

($ in thousands)

Operations

	Nine Months Ended September 30	
	2016	2015
Unrestricted revenues		
Net patient service revenue	$ 5,596,257	$ 4,855,743
Provision for uncollectible accounts	(240,991)	(196,124)
Net patient service revenue less provision for uncollectible accounts	5,355,266	4,659,619
Other	579,461	473,257
Total unrestricted revenues	5,934,727	5,132,876
Expenses		
Salaries, wages, and benefits	3,333,454	2,775,421
Supplies	555,407	482,864
Pharmaceuticals	636,705	497,147
Purchased services and other fees	375,338	282,967
Administrative services	140,466	116,352
Facilities	255,677	215,754
Insurance	55,945	49,538
	5,352,992	4,420,043
Operating income before interest, depreciation, and amortization expenses	581,735	712,833
Interest	99,817	92,668
Depreciation and amortization	352,928	303,716
Operating income before special charges	128,990	316,449
Special charges	22,884	-
Operating income	106,106	316,449
Nonoperating gains and losses		
Investment return	365,646	(118,309)
Derivative losses	(67,682)	(28,966)
Other, net	(6,629)	(614)
Net nonoperating gains and losses	291,335	(147,889)
Excess of revenues over expenses	397,441	168,560

Unaudited Consolidated Statements of Operations and Changes in Net Assets (continued)

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at January 1, 2015	$ 5,998,053	$ 519,730	$ 284,712	$ 6,802,495
Excess of revenues over expenses	168,560	-	-	168,560
Donated capital and assets released from restrictions for capital purposes	3,342	(3,321)	-	21
Gifts and bequests	-	65,866	16,748	82,614
Transfer of net assets	23	(23)	-	-
Net investment loss	-	(5,507)	-	(5,507)
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(29,413)	-	(29,413)
Retirement benefits adjustment	(2,271)	-	-	(2,271)
Change in interests in foundations	-	(1,245)	63	(1,182)
Change in value of perpetual trusts	-	-	(227)	(227)
Net change in unrealized losses on nontrading investments	(4,942)	-	-	(4,942)
Other	184	-	-	184
Increase in net assets	164,896	26,357	16,584	207,837
Balances at September 30, 2015	$ 6,162,949	$ 546,087	$ 301,296	$ 7,010,332
Balances at January 1, 2016	$ 6,627,406	$ 586,276	$ 295,316	$ 7,508,998
Excess of revenues over expenses	397,441	-	-	397,441
Donated capital and assets released from restrictions for capital purposes	7,706	(6,702)	-	1,004
Gifts and bequests	-	35,647	12,384	48,031
Transfer of net assets	(391)	391	-	-
Net investment income	-	21,101	-	21,101
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(29,456)	-	(29,456)
Retirement benefits adjustment	(1,664)	-	-	(1,664)
Change in interests in foundations	-	335	-	335
Change in value of perpetual trusts	-	-	(4,998)	(4,998)
Net change in unrealized losses on nontrading investments	(179)	-	-	(179)
Other	(42,521)	-	-	(42,521)
Increase in net assets	360,392	21,316	7,386	389,094
Balances at September 30, 2016	$ 6,987,798	$ 607,592	$ 302,702	$ 7,898,092

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Nine Months Ended September 30	
	2016	2015
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 389,094	$ 207,837
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Loss on extinguishment of debt	3,925	-
Retirement benefits adjustment	1,664	2,271
Net realized and unrealized (gains) losses on investments	(355,297)	155,764
Depreciation and amortization	365,029	303,716
Provision for uncollectible accounts	240,991	196,124
Donated capital	(1,004)	(21)
Restricted gifts, bequests, investment income, and other	(64,469)	(75,698)
Accreted interest and amortization of bond premiums	(1,368)	(1,251)
Net loss in value of derivatives	36,715	9,995
Changes in operating assets and liabilities:		
Patient receivables	(348,838)	(221,059)
Other current assets	21,699	(18,726)
Other noncurrent assets	(37,986)	(22,492)
Accounts payable and other current liabilities	39,574	(7,264)
Other liabilities	(97,050)	(33,291)
Net cash provided by operating activities and net nonoperating gains and losses	192,679	495,905
Financing activities		
Proceeds from short-term borrowings, net	60,000	-
Proceeds from long-term borrowings	425,150	-
Payments for redemption of long-term debt	(148,260)	-
Principal payments on long-term debt	(93,436)	(64,691)
Debt issuance costs	(169)	-
Change in pledges receivables, trusts and interests in foundations	9,971	(2,067)
Restricted gifts, bequests, investment income, and other	64,469	75,698
Net cash provided by financing activities	317,725	8,940
Investing activities		
Expenditures for property and equipment, net	(426,081)	(293,457)
Net change in cash equivalents reported in long-term investments	(24,237)	216,744
Purchases of investments	(2,056,803)	(2,235,736)
Sales of investments	2,163,009	1,893,873
Net cash used in investing activities	(344,112)	(418,576)
Increase in cash and cash equivalents	166,292	86,269
Cash and cash equivalents at beginning of year	249,580	70,322
Cash and cash equivalents at end of period	$ 415,872	$ 156,591

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

The accompanying unaudited consolidated financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) for interim financial information. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation have been included and are of a normal and recurring nature. Operating results for the three and nine months ended September 30, 2016 are not necessarily indicative of the results to be expected for the year ending December 31, 2016. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2015.

2. Organization and Consolidation

The Cleveland Clinic Foundation (Foundation) is a nonprofit, tax-exempt, Ohio corporation organized and operated to provide medical and hospital care, medical research, and education. The accompanying consolidated financial statements include the accounts of the Foundation and its controlled affiliates, d.b.a. Cleveland Clinic Health System (System).

The System is the leading provider of healthcare services in northeast Ohio. The System operates thirteen hospitals with approximately 3,900 staffed beds. Twelve of the hospitals are operated in the Northeast Ohio area, anchored by the Foundation. The System operates twenty-one outpatient Family Health Centers, ten ambulatory surgery centers, as well as numerous physician offices located throughout a seven-county area of northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada, and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that is part of Mubadala Development Company's network of healthcare facilities located in Abu Dhabi, United Arab Emirates with approximately 250 staffed beds, and in cooperation with Abu Dhabi Health Services Company, the Sheikh Khalifa Medical City, a network of healthcare facilities in Abu Dhabi, United Arab Emirates with approximately 711 staffed beds.

In November 2015, the Foundation became the sole member of Akron General Health System (Akron General), an integrated healthcare delivery system with a 532-registered bed flagship medical center located in Akron, Ohio. In addition to the flagship medical center, Akron General also includes Lodi Community Hospital, Edwin Shaw Rehabilitation Institute, three health and wellness centers, Visiting Nurse Services and affiliates, a physician group practice and other outpatient locations. The System previously had a 35% special membership interest in Akron General pursuant to an affiliation agreement effective in September 2014 that was accounted for under the equity method of accounting.

All significant intercompany balances and transactions have been eliminated in consolidation.

3. Accounting Policies

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*, which outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance, and requires significantly expanded disclosures about revenue recognition. The core principle of the revenue model is that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The guidance is effective for the System as of January 1, 2018. The System is currently evaluating the impact on the consolidated financial statements and the options of adopting using either a full retrospective or a modified approach.

In April 2015, the FASB issued ASU 2015-03, *Imputation of Interest, Simplifying the Presentation of Debt Issuance Costs*. This ASU requires debt issuance costs to be presented in the balance sheet as a direct deduction from the associated debt liability, consistent with the presentation of a debt discount. This amends guidance that required debt issuance costs to be presented as assets on the balance sheet. ASU 2015-03 is effective for the System for reporting periods beginning after December 15, 2015. The System adopted the provisions of ASU 2015-03 on January 1, 2016 and retrospectively adjusted all periods presented in the consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases*. This ASU requires lessees to recognize assets and liabilities on the balance sheet for leases with lease terms greater than twelve months. The recognition, measurement and presentation of expenses and cash flows arising from a lease by a lessee primarily will depend on its classification as a finance or operating lease. This amends current guidance that requires only capital leases to be recognized on the lessee balance sheet. ASU 2016-02 will also require additional disclosures on the amount, timing and uncertainty of cash flows arising from leases. The guidance is effective for the System for reporting periods beginning after December 15, 2018 with early adoption permitted. The System is currently evaluating the impact that ASU 2016-02 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

In August 2016, the FASB issued ASU 2016-14*, Presentation of Financial Statement of Not-for-Profit Entities*. Under the provisions of ASU 2016-14, not-for-profit entities will no longer be required to distinguish between resources with temporary and permanent restrictions on the face of their financial statements, meaning net assets will be presented in two classes instead of three. Not-for-profit entities will be required to present expenses by their natural and functional classification and present investment returns net of external and direct internal investment expenses. Not-for-profit entities also will be required to provide more information about their available resources and liquidity. The guidance is effective for the System for reporting periods beginning after December 15, 2017 with early adoption permitted. The System is currently evaluating the impact that ASU 2016-14 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

3. Accounting Policies (continued)

Change in Accounting Principle

In 2016, the System changed the method for reporting and amortizing debt issuance costs associated with long-term debt in accordance with ASU 2015-03. The new method presents debt issuance costs as a deduction from the associated liability, consistent with the presentation of a debt discount. The new method also records the amortization of debt issuance costs as interest expense. Previously, debt issuance costs were reported in other noncurrent assets in the consolidated balance sheets, and the related amortization was recorded as amortization expense. The new method is preferable because it makes the presentation of debt issuance costs consistent with the presentation of debt discounts and premiums.

The change has been applied retrospectively, and therefore, debt issuance costs and the related amortization have been updated for all periods presented in the consolidated financial statements. The accounting change had no impact on previously reported excess of revenues over expenses or net assets.

3. Accounting Policies (continued)

As a result of the adoption of ASU 2015-03, the System reclassified $22.5 million and $23.2 million from other noncurrent assets to long-term debt as of September 30, 2016 and December 31, 2015, respectively. The following table presents the impact of the change in accounting principle for debt issuance costs on the consolidated statements of operations and changes in net assets and consolidated statements of cash flows (in thousands):

	Nine months Ended September 30, 2016		
	Previous Accounting Method	**Impact of Accounting Change**	**As Reported**
Consolidated Statement of Operations and Changes in Net Assets			
Interest	**$ 99,164**	**$ 653**	**$ 99,817**
Depreciation and amortization	**353,581**	**(653)**	**352,928**
Consolidated Statement of Cash Flows			
Accreted interest and amortization of bond premiums	**$ (2,021)**	**$ 653**	**$ (1,368)**
Depreciation and amortization	**365,682**	**(653)**	**365,029**

	Nine months Ended September 30, 2015		
	Previous Accounting Method	**Impact of Accounting Change**	**As Adjusted**
Consolidated Statement of Operations and Changes in Net Assets			
Interest	$ 92,019	$ 649	$ 92,668
Depreciation and amortization	304,365	(649)	303,716
Consolidated Statement of Cash Flows			
Accreted interest and amortization of bond premiums	$ (1,900)	$ 649	$ (1,251)
Depreciation and amortization	304,365	(649)	303,716

4. Use of Estimates

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

5. Net Patient Service Revenue and Patient Receivables

Net patient service revenue before the provision for uncollectible accounts by major payor source for the nine months ended September 30, 2016 and 2015, are as follows (in thousands):

	2016		**2015**	
Medicare	**$ 1,870,477**	**33%**	$ 1,462,806	30%
Medicaid	**430,434**	**8**	345,880	7
Managed care and commercial	**3,148,114**	**56**	2,899,310	60
Self-pay	**147,232**	**3**	147,747	3
	$ 5,596,257	**100%**	$ 4,855,743	100%

An estimated provision for uncollectible accounts is recorded that results in net patient service revenue being reported at the net amount expected to be received. The System has determined, based on an assessment at the consolidated entity level, that patient service revenue is primarily recorded prior to assessing the patient's ability to pay and as such, the entire provision for uncollectible accounts related to patient service revenue is recorded as a deduction from patient service revenue.

The System records an estimated provision for uncollectible accounts in the year of service for patient receivables associated with self-pay patients, including patients with deductible and copayment balances for which third-party coverage provides for a portion of the services provided. The System has experienced an increase in Medicaid revenue resulting from expansion of Medicaid eligibility in the State of Ohio and an increase in deductible and copayment balances as a result of industry trends. Self-pay write-offs increased $51.5 million in the first nine months of 2016 compared to the same period in 2015. The System does not maintain a material allowance for uncollectible accounts from third-party payors.

The allowance for uncollectible accounts is based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in healthcare coverage, major payor sources and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category. The results of this review are then used to make modifications to the provision for uncollectible accounts to establish an appropriate allowance for uncollectible receivables. The System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System and in compliance with Internal Revenue Code 501(r).

6. Fair Value Measurements

Fair value measurements are defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

The framework for measuring fair value is comprised of a three-level hierarchy based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 – inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.

- Level 2 – inputs to the valuations methodology include quoted prices for similar assets or liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument.

- Level 3 – inputs to the valuation methodology are unobservable and significant to the fair value measurement.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The carrying values of accounts receivable and accounts payable are reasonable estimates of fair value due to the short-term nature of these financial instruments. Investments, other than alternative investments, are recorded at their fair value. Other noncurrent assets and liabilities have carrying values that approximate fair value.

The fair value of the System's pledges receivable is based on discounted cash flow analysis using treasury yield curve interest rates consistent with the maturities of the pledges receivable and adjusted for consideration of the donor's credit. The fair value of pledges receivable was $183.7 million and $185.4 million at September 30, 2016 and December 31, 2015, respectively. The carrying value of the System's pledges receivable was $173.2 million and $179.2 million at September 30, 2016 and December 31, 2015, respectively. Pledges receivable would be classified as Level 3 in the fair value hierarchy.

The fair value of the System's long-term debt is estimated by discounted cash flow analyses using current borrowing rates for similar types of borrowing arrangements and adjusted for the System's credit. Inputs, which include reported/comparable trades, broker/dealer quotes, bids and offerings, are obtained from various sources, including market participants, dealers, brokers and various news media/market information. The fair value of long-term debt was $3.7 billion at September 30, 2016 and $3.5 billion at December 31, 2015, respectively. The carrying value of the System's long-term debt was $3.5 billion at September 30, 2016 and $3.3 billion at December 31, 2015. Long-term debt would be classified as Level 2 in the fair value hierarchy.

6. Fair Value Measurements (continued)

The following tables present the financial instruments measured at fair value on a recurring basis as of September 30, 2016 and December 31, 2015, based on the valuation hierarchy (in thousands):

September 30, 2016	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	**$ 752,929**	**$ 27**	**$ –**	**$ 752,956**
Fixed income securities:				
U.S. treasuries	**858,785**	**–**	**–**	**858,785**
U.S. government agencies	**–**	**21,132**	**–**	**21,132**
U.S. corporate	**–**	**167,908**	**–**	**167,908**
U.S. government agencies asset-backed securities	**–**	**23,950**	**–**	**23,950**
Corporate asset-backed securities	**–**	**2,990**	**–**	**2,990**
Foreign	**–**	**39,676**	**–**	**39,676**
Fixed income mutual funds	**196,059**	**–**	**–**	**196,059**
Common and preferred stocks:				
U.S.	**414,350**	**1,987**	**–**	**416,337**
Foreign	**262,334**	**1,623**	**–**	**263,957**
Equity mutual funds	**329,814**	**–**	**–**	**329,814**
Total cash and investments	**2,814,271**	**259,293**	**–**	**3,073,564**
Perpetual and charitable trusts	**–**	**60,979**	**–**	**60,979**
Total assets at fair value	**$2,814,271**	**$ 320,272**	**$ –**	**$ 3,134,543**
Liabilities				
Interest rate swaps	**$ –**	**$ 196,048**	**$ –**	**$ 196,048**
Foreign exchange contracts	**$ –**	**$ 10,968**	**$ –**	**$ 10,968**
Total liabilities at fair value	**$ –**	**$ 207,016**	**$ –**	**$ 207,016**

6. Fair Value Measurements (continued)

December 31, 2015	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 562,350	$ 56	$ –	$ 562,406
Fixed income securities:				
U.S. treasuries	810,036	–	–	810,036
U.S. government agencies	–	22,158	–	22,158
U.S. corporate	–	147,703	–	147,703
U.S. government agencies asset-backed securities	–	18,519	–	18,519
Corporate asset-backed securities	–	7,295	–	7,295
Foreign	–	40,774	–	40,774
Fixed income mutual funds	172,996	–	–	172,996
Common and preferred stocks:				
U.S.	416,316	1,819	–	418,135
Foreign	251,046	1,330	–	252,376
Equity mutual funds	262,774	–	–	262,774
Total cash and investments	2,475,518	239,654	–	2,715,172
Perpetual and charitable trusts	–	65,305	–	65,305
Total assets at fair value	$ 2,475,518	$ 304,959	$ –	$ 2,780,477
Liabilities				
Interest rate swaps	$ –	$ 159,333	$ –	$ 159,333
Total liabilities at fair value	$ –	$ 159,333	$ –	$ 159,333

6. Fair Value Measurements (continued)

Financial instruments at September 30, 2016 and December 31, 2015 are reflected in the consolidated balance sheets as follows (in thousands):

	September 30 2016	December 31 2015
Cash, cash equivalents, and investments measured at fair value	**$ 3,073,564**	$ 2,715,172
Commingled funds measured at net asset value	**2,392,943**	2,261,000
Alternative investments accounted for under the equity method	**2,245,469**	2,296,184
Total cash, cash equivalents, and investments	**$ 7,711,976**	$ 7,272,356
Perpetual and charitable trusts measured at fair value	**$ 60,979**	$ 65,305
Interests in foundations	**21,771**	21,436
Trusts and interests in foundations	**$ 82,750**	$ 86,741

Interest rate swaps (Note 7) are reported in other noncurrent liabilities in the consolidated balance sheets.

The following is a description of the System's valuation methodologies for assets and liabilities measured at fair value. Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is determined as follows:

Investments classified as Level 2 are primarily determined using techniques that are consistent with the market approach. Valuations are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs, which include broker/dealer quotes, reported/comparable trades, and benchmark yields, are obtained from various sources, including market participants, dealers, and brokers.

The fair value of perpetual and charitable trusts in which the System receives periodic payments from the trust is determined based on the present value of expected cash flows to be received from the trust using discount rates ranging from 1.9% to 5.0%, which are based on Treasury yield curve interest rates or the assumed yield of the trust assets. The fair value of charitable trusts in which the System is a remainder beneficiary is based on the System's beneficial interest in the investments held in the trust, which are measured at fair value.

6. Fair Value Measurements (continued)

The fair value of interest rate swaps is determined based on the present value of expected future cash flows using discount rates appropriate with the risks involved. The valuations include a credit spread adjustment to market interest rate curves to appropriately reflect nonperformance risk. The credit spread adjustment is derived from other comparably rated entities' bonds recently priced in the market. The System manages credit risk based on the net portfolio exposure with each counterparty.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

7. Derivative Instruments

The System has entered into various derivative financial instruments to manage interest rate risk and foreign currency exposures. Derivative financial instruments are reported in the consolidated balance sheets at fair value. Changes in the fair value of derivatives are recognized in derivative losses on the consolidated statement of operations and changes in net assets.

The System's objective with respect to interest rate risk is to manage the risk of rising interest rates on the System's variable rate debt and certain variable rate operating lease payments. Consistent with its interest rate risk management objective, the System entered into various interest rate swap agreements with a total outstanding notional amount of $637.8 million and $653.1 million at September 30, 2016 and December 31, 2015, respectively. During the term of these transactions, the System pays interest at a fixed rate and receives interest at a variable rate based on the London Interbank Offered Rate (LIBOR) or the Securities Industry and Financial Markets Association Index (SIFMA). The swap agreements are not designated as hedging instruments. Net interest paid or received under the swap agreements is included in derivative losses in the consolidated statements of operations and changes in net assets.

7. Derivative Instruments (continued)

The following table summarizes the System's interest rate swap agreements (in thousands):

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at September 30 2016	Notional Amount at December 31 2015
Fixed	2016	5.28%	100% of SIFMA	**$ -**	$ 4,150
Fixed	2021	3.21%	68% of LIBOR	**33,265**	34,770
Fixed	2024	3.42%	68% of LIBOR	**27,800**	28,300
Fixed	2027	3.56%	68% of LIBOR	**128,333**	132,212
Fixed	2028	5.12%	100% of LIBOR	**38,800**	39,815
Fixed	2028	3.51%	68% of LIBOR	**29,965**	30,755
Fixed	2030	5.07%	100% of LIBOR	**62,500**	62,500
Fixed	2030	5.06%	100% of LIBOR	**62,500**	62,500
Fixed	2031	3.04%	68% of LIBOR	**52,625**	53,900
Fixed	2032	4.32%	79% of LIBOR	**2,381**	2,438
Fixed	2032	4.33%	70% of LIBOR	**4,763**	4,874
Fixed	2032	3.78%	70% of LIBOR	**2,381**	2,438
Fixed	2036	4.90%	100% of LIBOR	**50,000**	50,000
Fixed	2036	4.90%	100% of LIBOR	**79,375**	79,375
Fixed	2037	4.62%	100% of SIFMA	**63,135**	65,030
				$ 637,823	$ 653,057

The System is exposed to fluctuations in various foreign currencies against its functional currency, the U.S. dollar (USD). The System uses foreign currency derivatives including currency forward agreements and currency options to manage its exposure to fluctuations in the USD - British Pound (GBP) exchange rate. Currency forward agreements involve fixing the USD - GBP exchange rate for delivery of a specified amount of foreign currency on a specified date. The currency forward agreements are typically cash settled in USD for their fair value at or close to their settlement date. The System also has currency option contracts to manage its foreign currency exchange risk.

In June 2016, the System entered into five foreign currency (FX) contract agreements, expiring between September 2016 and September 2017, with a total outstanding notional amount of $125 million at September 30, 2016. The FX contract agreements are not designated as hedging instruments.

7. Derivative Instruments (continued)

The following table summarizes the location and fair value for the System's derivative instruments (in thousands):

	Derivatives Liability			
	September 30, 2016		**December 31, 2015**	
	Balance Sheet Location	**Fair Value**	**Balance Sheet Location**	**Fair Value**
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 196,048**	Other noncurrent liabilities	$ 159,333
Foreign currency contracts	Other current liabilities	**10,968**		-
		$ 207,016		$ 159,333

The following table summarizes the location and amounts of derivative losses on the System's derivative instruments (in thousands):

Derivatives not designated as hedging instruments	**Location of (Loss) Gain Recognized**	**Quarter ended September 30**		**Nine months ended September 30**	
		2016	**2015**	**2016**	**2015**
Interest rate swap agreements	Derivative losses	**$ (101)**	$ (28,849)	**$ (55,196)**	$ (28,966)
Foreign currency contracts	Derivative losses	**(2,721)**	-	**(12,486)**	-
		$ (2,822)	$ (28,849)	**$ (67,682)**	$ (28,966)

The System has used various derivative contracts in connection with certain prior obligations and investments. Although minimum credit ratings are required for counterparties, this does not eliminate the risk that a counterparty may fail to honor its obligations. Derivative contracts are subject to periodic "mark-to-market" valuations. A derivative contract may, at any time, have a positive or negative value to the System. In the event that the negative value reaches certain thresholds established in the derivative contracts, the System is required to post collateral, which could adversely affect its liquidity. At September 30, 2016 and December 31, 2015, the System posted $133.7 million and $94.1 million, respectively, of collateral with counterparties that is included in funds held by trustees in the consolidated balance sheets. In addition, if the System were to choose to terminate a derivative contract or if a derivative contract were terminated pursuant to an event of default or a termination event as described in the derivative contract, the System could be required to pay a termination payment to the counterparty.

8. Pensions and Other Postretirement Benefits

The System has four defined benefit pension plans, including two plans assumed by the System from the Akron General member substitution. The CCHS Retirement Plan covers substantially all employees of the System except those employed by Akron General. The CCHS Retirement Plan ceased benefit accruals as of December 31, 2009 for substantially all employees, with benefit accruals for remaining employees ceasing at various intervals through December 31, 2012. Akron General has a defined benefit plan covering substantially all of its employees that were hired before 2004 who meet certain eligibility requirements. In 2009, Akron General ceased benefit accruals for substantially all nonunion employees. Benefits for union employees ceased at various intervals through 2013 except in certain circumstances. The benefits for the System's defined benefit pension plans are provided based on age, years of service, and compensation. The System's policy for its defined benefit pension plans is to fund at least the minimum amounts required by the Employee Retirement Income Security Act. The System also maintains two nonqualified defined benefit supplemental retirement plans, which cover certain of its employees.

The System sponsors two noncontributory, defined contribution plans, and three contributory, defined contribution plans, including two contributory defined contribution plans assumed by the System from the Akron General member substitution. The Cleveland Clinic Investment Pension Plan (IPP) is a noncontributory, defined contribution plan, which covers substantially all of the System's employees except those employed by Akron General. The System's contribution for the IPP is based upon a percentage of employee compensation and years of service. The System sponsors an additional noncontributory, defined contribution plan, which covers certain of its employees. The System's contribution to the plan is based upon a percentage of employee compensation, as defined, determined according to age. The System also sponsors three contributory, defined contribution plans, including two plans at Akron General, which cover substantially all employees. Any System contribution to the applicable contributory plan is determined based on employee contributions.

The components of net periodic benefit cost are as follows (in thousands):

	Quarter Ended September 30		Nine Months Ended September 30	
	2016	**2015**	**2016**	**2015**
Amounts related to defined benefit pension plans:				
Service cost	$ 545	$ 585	$ 1,634	$ 1,756
Interest cost	19,019	16,057	57,056	48,172
Expected return on assets	(19,864)	(20,596)	(59,592)	(61,787)
Net amortization and deferral	(420)	(420)	(1,261)	(1,261)
Total defined benefit pension plans	(720)	(4,374)	(2,163)	(13,120)
Defined contribution plans	51,522	44,746	164,287	146,980
	$ 50,802	**$ 40,372**	**$ 162,124**	**$ 133,860**

As of September 30, 2016, the System has made contributions of $127.4 million to the defined benefit pension plans. The System expects to make additional contributions of $1.6 million to the defined benefit pension plans for the remainder of 2016.

9. Debt

In January 2016, the System entered into a line of credit with a financial institution totaling $60.0 million. The System drew the full amount on the line of credit and also issued $100.0 million of Taxable Hospital Revenue Commercial Paper Notes (Series 2014A CP Notes). A portion of the proceeds from the draw on the line of credit and the issuance of the Series 2014A CP Notes were used to defease the Series 2012 Akron Bonds and redeem the Series 2012 taxable Akron Bonds, the Series 2014A Akron Bonds and the Series 2014B Akron Bonds.

In August 2016, the Foundation issued private placement notes (Notes) totaling $325.0 million that were purchased by a financial institution. The Notes mature in 2046 and bear interest at a fixed rate of 3.35%. The proceeds of the Notes were used for the general corporate purposes of the Foundation.

In September 2016, the Foundation entered into a $300.0 million revolving credit facility with multiple financial institutions. The revolving credit facility expires in 2019 with provisions allowing the Foundation to extend the term for one-year periods. The revolving credit facility bears interest at a variable rate based on the London Interbank Offered Rate (LIBOR) plus an applicable spread. Amounts outstanding on the revolving credit facility as of September 30, 2016 totaled $60.0 million. The proceeds were used to pay the full outstanding amount on the line of credit that was executed in January 2016.

10. Special Charges

The System incurred and recorded $22.9 million of special charges in the first nine months of 2016. Special charges include $7.7 million of statutory compensation payments related to the termination of tenant leases at 33 Grosvenor Place Limited. The System has established a plan to convert the building from office space to a healthcare facility upon receiving the necessary approvals from local authorities. Special charges also include $15.2 million of accelerated depreciation and other costs related to Lakewood Hospital and the agreement entered into between the City of Lakewood, Lakewood Hospital Association (LHA) and the Foundation in December 2015 that outlines the transition of healthcare services in the City of Lakewood. Participation in the agreement by the City of Lakewood was authorized by an ordinance adopted by Lakewood City Council. Under the terms of the agreement, the Foundation and LHA will make contributions over the next eighteen years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Foundation will construct, own and operate an approximately 62,000-square-foot family health center expected to open in 2018 that will be located adjacent to the current site of the hospital. LHA ceased inpatient operations at the hospital in February 2016, while the emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The Lakewood Hospital site is currently leased by LHA from the City of Lakewood, and clinical services at that location are operated by the Foundation since the cessation of inpatient operations. The cessation of inpatient services at the hospital is not considered a discontinued operation since the System provides inpatient hospital services at the Foundation and its subsidiary hospitals in the Northeast Ohio area.

11. Subsequent Events

The System evaluated events and transactions occurring subsequent to September 30, 2016 through November 29, 2016, the date the unaudited consolidated financial statements were issued. During this period, there were no subsequent events requiring recognition in the unaudited consolidated financial statements. In addition there were no nonrecognized subsequent events requiring disclosure, except that in November 2016, the System entered into a loan agreement with a financial institution totaling $17.4 million. The loan matures in 2026 and bears interest at a variable rate based on the LIBOR index rate plus an applicable spread. The proceeds of the loan were used to pay a portion of the outstanding Series 2014A CP Notes.

Unaudited Consolidating Balance Sheets

($ in thousands)

	September 30, 2016				December 31, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 410,037	$ 5,835	$ -	$ 415,872	$ 176,869	$ 72,711	$ -	$ 249,580
Patient receivables, net	987,923	97,749	(27,521)	1,058,151	879,420	94,544	(23,660)	950,304
Due from affiliates	12,512	44,710	(57,222)	-	916	40	(956)	-
Investments for current use	-	52,223	-	52,223	-	53,852	-	53,852
Other current assets	304,530	87,618	(12,557)	379,591	343,901	66,682	(2,444)	408,139
Total current assets	1,715,002	288,135	(97,300)	1,905,837	1,401,106	287,829	(27,060)	1,661,875
Investments:								
Long-term investments	5,995,714	377,537	-	6,373,251	5,813,363	371,015	-	6,184,378
Funds held by trustees	148,431	-	-	148,431	116,046	9,677	-	125,723
Assets held for self-insurance	-	117,619	-	117,619	-	93,662	-	93,662
Donor restricted assets	559,589	44,991	-	604,580	520,474	44,687	-	565,161
	6,703,734	540,147	-	7,243,881	6,449,883	519,041	-	6,968,924
Property, plant, and equipment, net	3,455,417	983,773	-	4,439,190	3,384,312	1,004,355	-	4,388,667
Other assets:								
Pledges receivable, net	141,317	1,020	-	142,337	140,137	1,331	-	141,468
Trusts and beneficial interests in foundations	74,787	7,963	-	82,750	77,416	9,325	-	86,741
Other noncurrent assets	492,661	123,835	(226,352)	390,144	325,550	81,249	(53,051)	353,748
	708,765	132,818	(226,352)	615,231	543,103	91,905	(53,051)	581,957
Total assets	$ 12,582,918	$ 1,944,873	$ (323,652)	$ 14,204,139	$ 11,778,404	$ 1,903,130	$ (80,111)	$ 13,601,423

	September 30, 2016				December 31, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable	$ 297,844	$ 77,235	$ (220)	$ 374,859	$ 345,228	$ 69,508	$ (2,177)	$ 412,559
Compensation and amounts withheld from payroll	324,766	37,679	-	362,445	253,615	42,053	-	295,668
Short-term borrowings	-	-	-	-	0	0	-	-
Current portion of long-term debt	234,581	5,470	-	240,051	84,392	11,302	-	95,694
Variable rate debt classified as current	396,976	60,909	-	457,885	371,825	149,135	-	520,960
Due to affiliates	14,306	27,541	(41,847)	-	27	929	(956)	-
Other current liabilities	370,717	121,094	(38,824)	452,987	379,854	111,115	(23,927)	467,042
Total current liabilities	1,639,190	329,928	(80,891)	1,888,227	1,434,941	384,042	(27,060)	1,791,923
Long-term debt:								
Hospital revenue bonds	2,909,665	-	-	2,909,665	2,667,806	57,954	-	2,725,760
Notes payable and capital leases	132,782	548,226	(222,904)	458,104	95,327	420,296	(49,603)	466,020
	3,042,447	548,226	(222,904)	3,367,769	2,763,133	478,250	(49,603)	3,191,780
Other liabilities:								
Professional and general insurance liability reserves	52,480	108,530	-	161,010	52,587	87,030	-	139,617
Accrued retirement benefits	323,195	45,390	-	368,585	426,180	64,573	-	490,753
Other noncurrent liabilities	473,616	63,249	(16,409)	520,456	425,155	53,197	-	478,352
	849,291	217,169	(16,409)	1,050,051	903,922	204,800	-	1,108,722
Total liabilities	5,530,928	1,095,323	(320,204)	6,306,047	5,101,996	1,067,092	(76,663)	6,092,425
Net assets:								
Unrestricted	6,196,449	794,797	(3,448)	6,987,798	5,851,045	779,809	(3,448)	6,627,406
Temporarily restricted	570,252	37,340	-	607,592	548,408	37,868	-	586,276
Permanently restricted	285,289	17,413	-	302,702	276,955	18,361	-	295,316
Total net assets	7,051,990	849,550	(3,448)	7,898,092	6,676,408	836,038	(3,448)	7,508,998
Total liabilities and net assets	$ 12,582,918	$ 1,944,873	$ (323,652)	$ 14,204,139	$ 11,778,404	$ 1,903,130	$ (80,111)	$ 13,601,423

See notes to unaudited consolidated financial statements.

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group.

Unaudited Consolidating Statements of Operations and Changes in Net Assets
($ in thousands)

Operations

	Three Months Ended September 30, 2016				Three Months Ended September 30, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 1,720,999	$ 236,598	$ (75,824)	$ 1,881,773	$ 1,666,228	$ 54,621	$ (50,072)	$ 1,670,777
Provision for uncollectible accounts	(70,097)	(8,386)	-	(78,483)	(56,506)	(2,090)	-	(58,596)
Net patient service revenue less provision for uncollectible accounts	1,650,902	228,212	(75,824)	1,803,290	1,609,722	52,531	(50,072)	1,612,181
Other	169,811	82,662	(49,843)	202,630	137,376	55,057	(33,747)	158,686
Total unrestricted revenues	1,820,713	310,874	(125,667)	2,005,920	1,747,098	107,588	(83,819)	1,770,867
Expenses								
Salaries, wages, and benefits	1,034,186	144,415	(73,446)	1,105,155	932,362	52,246	(58,818)	925,790
Supplies	159,754	25,956	(282)	185,428	153,437	9,470	(391)	162,516
Pharmaceuticals	203,758	17,424	-	221,182	176,492	3,406	-	179,898
Purchased services and other fees	102,662	43,954	(15,603)	131,013	96,468	8,428	(3,368)	101,528
Administrative services	40,352	14,379	(6,294)	48,437	31,662	23,573	(6,118)	49,117
Facilities	66,309	16,470	(981)	81,798	71,983	7,016	(1,535)	77,464
Insurance	16,776	28,154	(29,061)	15,869	13,197	15,123	(13,589)	14,731
	1,623,797	290,752	(125,667)	1,788,882	1,475,601	119,262	(83,819)	1,511,044
Operating income (loss) before interest, depreciation, and amortization expenses	196,916	20,122	-	217,038	271,497	(11,674)	-	259,823
Interest	32,331	2,428	-	34,759	30,383	606	-	30,989
Depreciation and amortization	102,377	17,832	-	120,209	95,569	5,282	-	100,851
Operating income (loss) before special charges	62,208	(138)	-	62,070	145,545	(17,562)	-	127,983
Special charges	-	3,650	-	3,650	-	-	-	-
Operating income (loss)	62,208	(3,788)	-	58,420	145,545	(17,562)	-	127,983
Nonoperating gains and losses								
Investment return	216,957	15,949	-	232,906	(260,734)	(17,234)	-	(277,968)
Derivative losses	(2,180)	(642)	-	(2,822)	(28,102)	(747)	-	(28,849)
Other, net	(37)	(833)	-	(870)	(342)	-	-	(342)
Net nonoperating gains and losses	214,740	14,474	-	229,214	(289,178)	(17,981)	-	(307,159)
Excess (deficiency) of revenues over expenses	276,948	10,686	-	287,634	(143,633)	(35,543)	-	(179,176)

Unaudited Consolidating Statements of Operations and Changes in Net Assets (continued)

($ in thousands)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at July 1, 2015	$ 6,646,713	$ 530,184	$ (3,448)	$ 7,173,449
Deficiency of revenues over expenses	(143,633)	(35,543)	-	(179,176)
Restricted gifts and bequests	44,342	1,884	-	46,226
Restricted net investment loss	(16,539)	(303)	-	(16,842)
Net assets released from restrictions used for operations included in other unrestricted revenues	(7,215)	(512)	-	(7,727)
Retirement benefits adjustment	(757)	-	-	(757)
Change in restricted net assets related to interests in foundations	(1,552)	19	-	(1,533)
Change in restricted net assets related to value of perpetual trusts	(303)	(111)	-	(414)
Net change in unrealized losses on nontrading investments	(2,557)	-	-	(2,557)
Other	(89)	(249)	1	(337)
Decrease in total net assets	(128,303)	(34,815)	1	(163,117)
Total net assets at September 30, 2015	$ 6,518,410	$ 495,369	$ (3,447)	$ 7,010,332
Total net assets at July 1, 2016	$ 6,796,546	$ 837,509	$ (3,448)	$ 7,630,607
Excess of revenues over expenses	276,948	10,686	-	287,634
Donated capital, excluding assets released from restrictions for capital purposes	31	41	-	72
Restricted gifts and bequests	15,511	1,454	-	16,965
Restricted net investment income	13,068	852	-	13,920
Net assets released from restrictions used for operations included in other unrestricted revenues	(9,353)	(1,288)	-	(10,641)
Transfers (to) from affiliates	(39,218)	39,218	-	-
Retirement benefits adjustment	(555)	-	-	(555)
Change in restricted net assets related to interests in foundations	697	-	-	697
Change in restricted net assets related to value of perpetual trusts	(1,771)	(358)	-	(2,129)
Net change in unrealized gains on nontrading investments	52	-	-	52
Other	34	(38,564)	-	(38,530)
Increase in total net assets	255,444	12,041	-	267,485
Total net assets at September 30, 2016	$ 7,051,990	$ 849,550	$ (3,448)	$ 7,898,092

See notes to unaudited consolidated financial statements.

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group.

Unaudited Consolidating Statements of Operations and Changes in Net Assets (continued)

($ in thousands)

Operations

	Nine Months Ended September 30, 2016				Nine Months Ended September 30, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 5,111,405	$ 671,754	$ (186,902)	$ 5,596,257	$ 4,832,256	$ 172,297	$ (148,810)	$ 4,855,743
Provision for uncollectible accounts	(212,529)	(28,462)	-	(240,991)	(189,821)	(6,303)	-	(196,124)
Net patient service revenue less provision for uncollectible accounts	4,898,876	643,292	(186,902)	5,355,266	4,642,435	165,994	(148,810)	4,659,619
Other	472,852	226,472	(119,863)	579,461	403,673	167,800	(98,216)	473,257
Total unrestricted revenues	5,371,728	869,764	(306,765)	5,934,727	5,046,108	333,794	(247,026)	5,132,876
Expenses								
Salaries, wages, and benefits	3,098,146	439,083	(203,775)	3,333,454	2,793,379	156,172	(174,130)	2,775,421
Supplies	479,384	76,765	(742)	555,407	452,085	31,442	(663)	482,864
Pharmaceuticals	586,136	50,569	-	636,705	485,894	11,253	-	497,147
Purchased services and other fees	300,098	97,057	(21,817)	375,338	268,512	23,837	(9,382)	282,967
Administrative services	116,908	42,291	(18,733)	140,466	81,979	52,148	(17,775)	116,352
Facilities	206,046	52,626	(2,995)	255,677	200,077	19,986	(4,309)	215,754
Insurance	50,184	64,464	(58,703)	55,945	44,594	45,711	(40,767)	49,538
	4,836,902	822,855	(306,765)	5,352,992	4,326,520	340,549	(247,026)	4,420,043
Operating income (loss) before interest, depreciation, and amortization expenses	534,826	46,909	-	581,735	719,588	(6,755)	-	712,833
Interest	92,668	7,149	-	99,817	90,905	1,763	-	92,668
Depreciation and amortization	299,342	53,586	-	352,928	288,259	15,457	-	303,716
Operating income (loss) before special charges	142,816	(13,826)	-	128,990	340,424	(23,975)	-	316,449
Special charges	969	21,915	-	22,884	-	-	-	-
Operating income (loss)	141,847	(35,741)	-	106,106	340,424	(23,975)	-	316,449
Nonoperating gains and losses								
Investment return	337,970	27,676	-	365,646	(109,342)	(8,967)	-	(118,309)
Derivative losses	(65,612)	(2,070)	-	(67,682)	(26,692)	(2,274)	-	(28,966)
Other, net	240	(6,869)	-	(6,629)	(561)	(53)	-	(614)
Net nonoperating gains and losses	272,598	18,737	-	291,335	(136,595)	(11,294)	-	(147,889)
Excess (deficiency) of revenues over expenses	414,445	(17,004)	-	397,441	203,829	(35,269)	-	168,560

Unaudited Consolidating Statements of Operations and Changes in Net Assets (continued)

($ in thousands)

Changes in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2015	$ 6,273,610	$ 532,333	$ (3,448)	$ 6,802,495
Excess (deficiency) of revenues over expenses	203,829	(35,269)	-	168,560
Donated capital, excluding assets released from restrictions for capital purposes	21	-	-	21
Restricted gifts and bequests	80,268	2,346	-	82,614
Restricted net investment (loss) income	(5,768)	261	-	(5,507)
Net assets released from restrictions used for operations included in other unrestricted revenues	(24,479)	(4,934)	-	(29,413)
Contributions from (to) affiliates	231	(231)	-	-
Retirement benefits adjustment	(2,271)	-	-	(2,271)
Change in restricted net assets related to interest in foundations	(1,366)	184	-	(1,182)
Change in restricted net assets related to value of perpetual trusts	(155)	(72)	-	(227)
Net change in unrealized losses on nontrading investments	(4,942)	-	-	(4,942)
Other	(568)	751	1	184
Increase (decrease) in total net assets	244,800	(36,964)	1	207,837
Total net assets at September 30, 2015	$ 6,518,410	$ 495,369	$ (3,447)	$ 7,010,332
Total net assets at January 1, 2016	$ 6,676,408	$ 836,038	$ (3,448)	$ 7,508,998
Excess (deficiency) of revenues over expenses	414,445	(17,004)	-	397,441
Donated capital, excluding assets released from restrictions for capital purposes	963	41	-	1,004
Restricted gifts and bequests	45,630	2,401	-	48,031
Restricted net investment income	19,431	1,670	-	21,101
Net assets released from restrictions used for operations included in other unrestricted revenues	(26,788)	(2,668)	-	(29,456)
Transfers (to) from affiliates	(72,089)	72,089	-	-
Retirement benefits adjustment	(1,664)	-	-	(1,664)
Change in restricted net assets related to interests in foundations	335	-	-	335
Change in restricted net assets related to value of perpetual trusts	(4,050)	(948)	-	(4,998)
Net change in unrealized losses on nontrading investments	(179)	-	-	(179)
Other	(452)	(42,069)	-	(42,521)
Increase in total net assets	375,582	13,512	-	389,094
Total net assets at September 30, 2016	$ 7,051,990	$ 849,550	$ (3,448)	$ 7,898,092

See notes to unaudited consolidated financial statements.

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group.

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Nine Months Ended September 30, 2016				Nine Months Ended September 30, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Operating activities and net nonoperating gains and losses								
Increase (decrease) in total net assets	$ 375,582	$ 13,512	$ -	$ 389,094	$ 244,800	$ (36,964)	$ 1	$ 207,837
Adjustments to reconcile increase (decrease) in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:								
Gain on extinguishment of debt	-	3,925	-	3,925	-	-	-	-
Retirement benefits adjustment	1,664	-	-	1,664	2,271	-	-	2,271
Net realized and unrealized (gains) losses on investments	(329,250)	(26,047)	-	(355,297)	146,123	9,641	-	155,764
Depreciation and amortization	299,342	65,687	-	365,029	288,259	15,457	-	303,716
Provision for uncollectible accounts	212,529	28,462	-	240,991	189,821	6,303	-	196,124
Donated capital	(963)	(41)	-	(1,004)	(21)	-	-	(21)
Restricted gifts, bequests, investment income, and other	(61,346)	(3,123)	-	(64,469)	(72,979)	(2,719)	-	(75,698)
Transfers to (from) affiliates	72,089	(72,089)	-	-	(231)	231	-	-
Accreted interest and amortization of bond premiums	(1,373)	5	-	(1,368)	(1,260)	9	-	(1,251)
Net loss (gain) in value of derivatives	43,596	(6,881)	-	36,715	9,995	-	-	9,995
Changes in operating assets and liabilities:								
Patient receivables	(321,032)	(31,667)	3,861	(348,838)	(223,711)	(396)	3,048	(221,059)
Other current assets	20,557	(65,237)	66,379	21,699	(48,535)	(38,524)	68,333	(18,726)
Other noncurrent assets	(168,512)	(42,775)	173,301	(37,986)	(25,706)	(16)	3,230	(22,492)
Accounts payable and other current liabilities	51,936	41,469	(53,831)	39,574	(4,463)	54,315	(57,116)	(7,264)
Other liabilities	(99,891)	19,250	(16,409)	(97,050)	(23,129)	4,104	(14,266)	(33,291)
Net cash provided by (used in) operating activities and net nonoperating gains and losses	94,928	(75,550)	173,301	192,679	481,234	11,441	3,230	495,905
Financing activities								
Proceeds from short-term borrowings, net	60,000	-	-	60,000	-	-	-	-
Proceeds from long-term borrowings	468,085	145,706	(188,641)	425,150	-	3,230	(3,230)	-
Payments for advance refunding of long-term debt	-	(148,260)	-	(148,260)	-	-	-	-
Principal payments on long-term debt	(82,817)	(25,959)	15,340	(93,436)	(59,723)	(4,968)	-	(64,691)
Debt issuance costs	(169)	-	-	(169)	-	-	-	-
Change in pledges receivable, trusts and interests in foundations	8,667	1,304	-	9,971	(4,763)	2,696	-	(2,067)
Restricted gifts, bequests, investment income, and other	61,346	3,123	-	64,469	72,979	2,719	-	75,698
Net cash provided by (used in) financing activities	515,112	(24,086)	(173,301)	317,725	8,493	3,677	(3,230)	8,940
Investing activities								
Expenditures for property and equipment	(380,182)	(45,899)	-	(426,081)	(285,634)	(7,823)	-	(293,457)
Net change in cash equivalents reported in long-term investments	(83,602)	59,365	-	(24,237)	218,525	(1,781)	-	216,744
Purchases of investments	(1,897,058)	(159,745)	-	(2,056,803)	(1,973,481)	(262,255)	-	(2,235,736)
Sales of investments	2,056,059	106,950	-	2,163,009	1,643,642	250,231	-	1,893,873
Transfers (to) from affiliates	(72,089)	72,089	-	-	231	(231)	-	-
Net cash (used in) provided by investing activities	(376,872)	32,760	-	(344,112)	(396,717)	(21,859)	-	(418,576)
Increase (decrease) in cash and cash equivalents	233,168	(66,876)	-	166,292	93,010	(6,741)	-	86,269
Cash and cash equivalents at beginning of year	176,869	72,711	-	249,580	2,952	67,370	-	70,322
Cash and cash equivalents at end of period	$ 410,037	$ 5,835	$ -	$ 415,872	$ 95,962	$ 60,629	$ -	$ 156,591

See notes to unaudited consolidated financial statements.

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group.

Utilization

The following table provides selected utilization statistics for The Cleveland Clinic Health System:

CLEVELAND CLINIC HEALTH SYSTEM

	Year Ended December 31			YTD September 30	
	2013	2014	2015[4]	2015[3]	2016
Total Staffed Beds[1]	3,535	3,565	4,034	4,042	3,856
Percent Occupancy[1]	67.7%	67.0%	68.0%	68.0%	69.4%
Inpatient Admissions[1]					
Acute	145,199	140,596	147,031	123,133	121,196
Post-acute	11,801	11,908	11,762	10,708	9,444
Total	157,000	152,504	158,793	133,841	130,640
Patient Days[1]					
Acute	759,553	746,293	787,161	641,926	632,793
Post-acute	99,205	99,701	97,956	89,409	79,196
Total	858,758	845,994	885,117	731,335	711,989
Average Length of Stay					
Acute	5.24	5.28	5.31	5.20	5.23
Post-acute	8.40	8.38	8.30	8.32	8.43
Surgical Facility Cases					
Inpatient	57,084	55,515	56,529	45,620	44,974
Outpatient	131,659	130,706	137,125	109,098	110,865
Total	188,743	186,221	193,654	154,718	155,839
Emergency Room Visits	475,777	497,631	542,418	478,047	491,665
Outpatient Observations	43,416	49,724	49,665	42,519	43,318
Outpatient Evaluation and Management Visits[2]	2,926,084	3,077,939	3,279,097	2,782,493	3,128,751
Acute Medicare Case Mix Index - Health System	1.87	1.90	1.91	1.90	1.97
Acute Medicare Case Mix Index - Cleveland Clinic	2.50	2.47	2.47	2.46	2.53
Total Acute Patient Case Mix Index - Health System	1.78	1.81	1.81	1.80	1.88
Total Acute Patient Case Mix Index - Cleveland Clinic	2.35	2.37	2.36	2.35	2.43

(1) Acute and post-acute, including rehabilitative and psychiatric services within post-acute, but excluding newborns and bassinets.
(2) Statistic is calculated based on Cleveland Clinic only.
(3) Pro Forma utilization statistics include Akron General.
(4) Includes Akron General statistics for November and December 2015. The Clinic became the sole member of Akron General on November 1, 2015.

Utilization (continued)

The following table provides selected utilization statistics for the obligated group:

TOTAL OBLIGATED GROUP

	Year Ended December 31			YTD September 30	
	2013	2014	2015	2015	2016
Total Staffed Beds[1]	3,260	3,297	3,352	3,325	3,343
Percent Occupancy[1]	69.0%	68.2%	69.7%	69.9%	70.1%
Inpatient Admissions[1]					
Acute	138,697	134,704	138,256	103,728	104,442
Post-acute	9,564	9,827	9,752	7,383	7,214
Total	148,261	144,531	148,008	111,111	111,656
Patient Days[1]					
Acute	734,783	722,977	751,700	560,246	559,933
Post-acute	70,666	71,989	73,576	55,521	57,569
Total	805,449	794,966	825,276	615,767	617,502
Surgical Facility Cases					
Inpatient	55,085	53,764	53,845	40,589	40,689
Outpatient	128,521	127,903	132,787	98,540	101,892
Total	183,606	181,667	186,632	139,129	142,581
Emergency Room Visits	442,113	464,981	494,037	369,958	402,826
Outpatient Observations	40,476	46,409	45,680	34,944	37,319
Outpatient Evaluation and Management Visits[2]	2,926,084	3,077,939	3,279,097	2,782,493	3,128,751
Acute Medicare Case Mix Index	1.83	1.85	1.86	1.90	1.97
Total Acute Patient Case Mix Index	1.74	1.76	1.76	1.80	1.88

(1) Acute and post-acute, including rehabilitative and psychiatric services within post-acute, but excluding newborns and bassinets.
(2) Statistic is calculated based on Cleveland Clinic only.

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group.

Payor Mix

The following table shows payor mix as a percentage of gross patient service revenue for the health system and obligated group as a whole:

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD September 30	
	2013	2014	2015[2]	2015[1]	2016
Payor					
Managed Care and Commercial	43%	43%	42%	41%	39%
Medicare	43%	43%	43%	43%	44%
Medicaid	8%	10%	12%	13%	14%
Self-Pay & Other	6%	4%	3%	3%	3%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD September 30	
	2013	2014	2015	2015	2016
Payor					
Managed Care and Commercial	43%	44%	42%	42%	39%
Medicare	43%	42%	43%	43%	45%
Medicaid	8%	10%	12%	12%	13%
Self-Pay & Other	6%	4%	3%	3%	3%
Total	100%	100%	100%	100%	100%

(1) Pro Forma payor mix includes Akron General.
(2) Includes Akron General payor mix for November and December 2015. The Clinic became the sole member of Akron General on November 1, 2015.

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group.

Research Support

($ in thousands)

The Clinic funds the annual cost of research from external sources, such as federal grants and contracts and contributions restricted for research, and internal sources, such as contributions, endowment earnings and revenue from operations. The following table summarizes the sources of research support for the Clinic:

	Year Ended December 31			YTD September 30	
	2013	2014	2015	2015	2016
External Grants Earned					
Federal Sources	$106,211	$97,327	$103,022	$76,079	$83,373
Non-Federal Sources	72,255	88,284	81,796	58,083	63,235
Total	178,466	185,611	184,818	134,162	146,608
Internal Support	67,259	66,758	63,240	50,439	47,083
Total Sources of Support	$245,725	$252,369	$248,058	$184,601	$193,691

Key Ratios

The following table provides selected key ratios for the System as a whole:

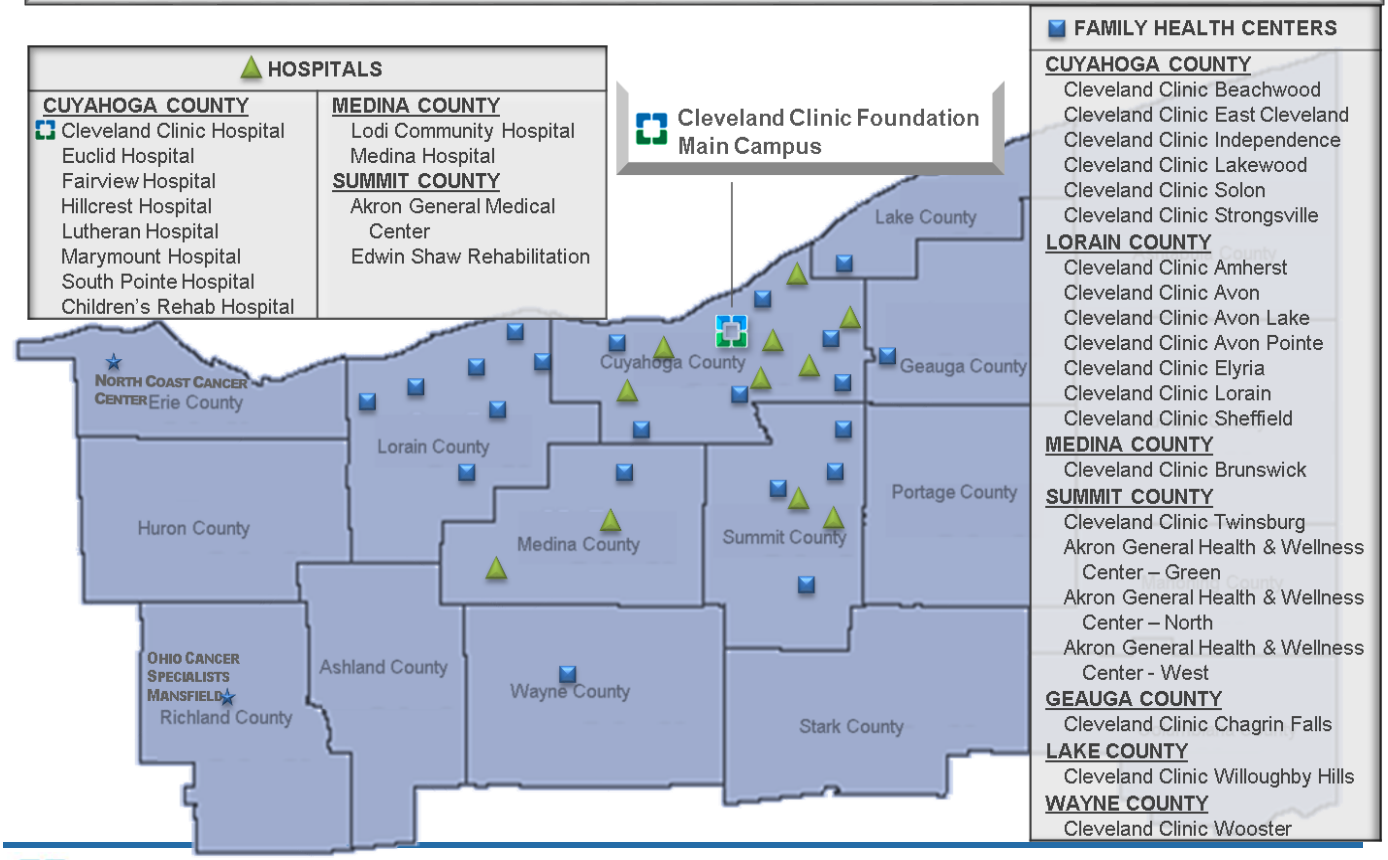
	Year Ended December 31			YTD Sep 30	
	2013	2014	2015	2015	2016
Liquidity ratios					
Days of cash on hand	323	377	347	371	340
Days of revenue in accounts receivable	48	47	47	48	54
Coverage ratios					
Cash to debt (%)	173.8	177.5	168.9	181.6	167.0
Maximum annual debt service coverage (x)	5.6	5.6	5.7	5.9	3.6
Interest expense coverage (x)	10.3	11.1	10.0	10.4	7.3
Debt to cash flow (x)	2.9	3.0	3.4	2.9	4.9
Leverage ratio					
Debt to capitalization (%)	35.0	36.1	36.5	35.3	36.8
Profitability ratios					
Operating margin (%)	4.6	7.0	6.7	6.2	1.8
Operating cash flow margin (%)	11.7	14.4	14.7	13.9	9.8
Excess margin (%)	12.8	10.2	8.5	3.4	6.4
Return on assets (%)	8.2	5.7	4.5	1.8	3.7

NOTES:
Coverage and liquidity ratios are calculated using a 12-month rolling income statement.
Certain prior period ratios have been restated to conform to the current presentation.

OVERVIEW

The Cleveland Clinic Health System (System) is a world-renowned provider of healthcare services and attracted patients from across the United States and from 180 other countries in 2015. The System operates thirteen hospitals with approximately 3,900 staffed beds and is the leading provider of healthcare services in northeast Ohio. Twelve of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates twenty-one outpatient Family Health Centers, ten ambulatory surgery centers, as well as numerous physician offices located throughout a seven-county area of northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that is part of Mubadala Development Company's network of healthcare facilities located in Abu Dhabi, United Arab Emirates with approximately 250 staffed beds, and, in cooperation with Abu Dhabi Health Services Company, the Sheikh Khalifa Medical City, a network of healthcare facilities in Abu Dhabi, United Arab Emirates with approximately 711 staffed beds.

CLEVELAND CLINIC HEALTH SYSTEM – NORTHEAST OHIO SERVICE AREA AND FACILITIES



The following table sets forth the number of staffed beds for the hospitals operated by the obligated group as well as the other entities in the System as of September 30, 2016:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,274
Euclid Hospital	221
Fairview Hospital	451
Hillcrest Hospital	453
Lutheran Hospital	194
Marymount Hospital	286
Medina Hospital	136
South Pointe Hospital	173
Weston Hospital	155
	3,343
NON-OBLIGATED	
Akron General Medical Center	433
Lodi Hospital	20
Edwin Shaw Rehabilitation Institute	35
Children's Rehab Hospital	25
	513
HEALTH SYSTEM	3,856

AWARDS & RECOGNITION

The Clinic was ranked as the second best hospital in the United States by *U.S. News and World Report* in its 2016-2017 edition of "America's Best Hospitals." This is the eighteenth consecutive year the Clinic was ranked among the top five hospitals in the United States. The Clinic's Heart and Vascular Institute, located on the Clinic's main campus, was recognized as the best cardiology and heart surgery program in the United States, an honor the Clinic has received annually for twenty-two consecutive years. The Clinic was nationally ranked in fourteen specialties, including nine in the top three nationwide, and is one of just twenty hospitals to earn a place on the *U.S. News'* 2016-2017 Honor Roll. The following table summarizes the Clinic's national rankings by medical specialty:

2016-17 U.S. NEWS & WORLD REPORT RANKINGS

BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2016-17

In the "HONOR ROLL"

Cleveland Clinic	2nd

Ranked No. 1

Cardiology & Heart Surgery	1st

In America's Top 3

Gastroenterology & GI Surgery	2nd
Nephrology	2nd
Urology	2nd
Diabetes & Endocrinology	3rd
Gynecology	3rd
Orthopedics	3rd
Pulmonology	3rd
Rheumatology	3rd

In America's Top 15

Neurology & Neurosurgery	6th
Cancer	8th
Geriatrics	8th
Ophthalmology	8th
Ear, Nose & Throat	12th

Cleveland Clinic Children's Hospital located on the Clinic's main campus ranked as one of the top pediatric hospitals in the country. The Children's Hospital earned national recognition in nine out of ten medical specialties ranked by *U.S. News and World Report* in its 2016-2017 edition of "Best Children's Hospitals." The following table summarizes the Clinic's national rankings by pediatric specialty:

The publication also evaluated hospitals by state and metropolitan area with a methodology similar to that used to determine the national rankings. The Clinic was ranked as the best hospital in both the state of Ohio and the Cleveland metropolitan area, which includes the City of Cleveland and its surrounding suburbs. The report also ranked two of the System's regional hospitals in the top hospitals in the Cleveland metropolitan area and Ohio: Fairview Hospital ranked third in Cleveland and fourth in Ohio and Hillcrest Hospital ranked fifth in Cleveland and twelfth in Ohio. Akron General Medical Center, located in Summit County, was ranked ninth in the state of Ohio. Weston Hospital was ranked first in the Miami-Fort Lauderdale metro area and fifth out of more than 250 hospitals in the state of Florida.

U.S. News and World Report created a list of the "Most Connected Hospitals" to recognize hospitals whose excellence in patient safety, patient engagement, and clinical connectedness improves patient care. The Clinic, Euclid, Fairview, Hillcrest, Lutheran, South Pointe and Weston hospitals were all included on the 2015-2016 list, which consisted of 159 hospitals nationwide. Selection for the list was based on hospitals' national ranking or high performing recognition on various *U.S News and World Report* lists as well as responses to certain questions from the 2013 and 2014 American Hospital Association Annual Survey Information Technology Supplements.

The Clinic has been named one of the World's Most Ethical Companies by the Ethisphere Institute for the sixth time in eight years. The 2016 award recognizes organizations that promote ethical business standards and practices internally, enable managers and employees to make good choices and shape future industry standards by introducing best

practices. Companies were evaluated in five categories: ethics and compliance programs; corporate citizenship and responsibility; culture of ethics; governance; and leadership, innovation and reputation.

The Clinic and Fairview Hospital received Healthgrades' 2016 Outstanding Patient Experience Award. Recipients of this award were chosen for providing outstanding performance in the delivery of positive experiences for patients based on achievement of clinical quality standards and the highest patient ratings from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey scores. Hospitals that received the award were in the top fifteen percent of HCAHPS scores nationally.

Medina Hospital earned the Joint Commission's Gold Seal of Approval for Hospital Accreditation. The hospital underwent an onsite survey during which Joint Commission surveyors evaluated compliance with hospital standards related to several areas, including emergency management, environment of care, infection prevention and control, leadership and medication management. The award represents a symbol of quality that reflects Medina Hospital's commitment to providing safe and effective patient care.

Lutheran Hospital and Medina Hospital both received the Vizient Bernard A. Birnbaum, MD, Quality Leadership Award for excellence in delivering safe, patient-centered care that is timely, effective, efficient, and equitable. In a list of 14 community hospitals recognized with this award, Lutheran placed first, and Medina placed ninth. More than 100 academic medical centers and 124 community hospitals were included in the study, which reviewed performance data from a variety of sources, including Vizient's clinical database, core measures data, the HCAHPS survey and the Center for Disease Control and Prevention's National Healthcare Safety Network.

The Clinic's Center for Continuing Education earned the highest level of accreditation, "Accreditation with Commendation," from the Accreditation Council for Continuing Medical Education, the governing body for continuing medical education providers. This accreditation is reserved for providers that comply with all criteria and accreditation policies. The Center is now accredited through 2021.

The Clinic has been named one of eight participants in a new four-year program of the Accreditation Council for Graduate Medical Education. The "Pursuing Excellence in Clinic Learning Environments" program aims to support and encourage innovation, promote transformative improvement in clinical learning environments and ultimately enhance patient care. The eight participants were chosen from a total of 47 applicants. Organizations were selected for their capacity to engage in transformational change and willingness to fully integrate a culture of learning into the clinical environment.

The Clinic has been awarded a nearly $5 million grant from the National Institutes of Health that will go towards an in-human clinical trial to assess deep brain stimulation as a therapy for stroke recovery patients. The grant expands the National Institutes of Health's efforts to develop new tools and technologies to understand how the brain functions and capture a dynamic view of the brain in action.

The Clinic was recognized by Becker's Healthcare in its 2016 edition of "150 Great Places to Work in Healthcare." Organizations were selected based on factors such as benefit offerings, wellness initiatives, professional development, diversity and inclusion, work-life balance and a sense of community among employees. Becker's Healthcare cited yoga

sessions, farmer's markets, on-site health clinics and professional development opportunities as contributors to the Clinic earning this recognition.

The Plain Dealer newspaper recognized the Clinic as one of Northeast Ohio's 100 top workplaces, ranking it fourteenth in the category for large local employers. This list was based on the opinions of employees who responded to a survey about leadership, values, training, work/life balance, compensation and benefits.

The Clinic was recognized for having a positive impact on its employees and the region with a NorthCoast 99 award, an annual recognition program that honors ninety-nine great workplaces in Northeast Ohio based on results from employee surveys. The Clinic has received this recognition eleven times.

The Clinic's CEO and President, Delos M. Cosgrove, M.D., was named the fifth most influential physician executive in the nation by Modern Healthcare in its 2016 list of the fifty most influential physician executives and leaders. The list honors physicians working in the healthcare industry who are recognized by their peers and an expert panel as being influential in terms of demonstrated leadership and impact. Dr. Cosgrove was recognized for his focus on the System's growth.

CORPORATE GOVERNANCE

The Board of Directors of the Clinic is responsible for all of its operations and affairs and controls its property. The Board of Directors is also responsible for ensuring that the Clinic is organized, and at all times operated, consistent with its charitable mission and its status as an Ohio nonprofit corporation and tax-exempt charitable organization. The Board of Directors generally meets eight times per year, including an annual meeting during which the Clinic's officers are elected and standing committees are appointed. The size of the Board of Directors can range between 15 to 25 Directors (currently there are 22 Directors). The Board of Trustees serves as an advisor to the Board of Directors. The Trustees actively serve on the committees of the Board of Directors. At present, there are 69 active Trustees and 11 Emeritus Trustees (not including Directors). Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

Cleveland Clinic Health Space
Cleveland, Ohio

The Board of Directors annually appoints certain committees to perform duties that it delegates to them from time to time, subject to ratification of such action by the Board of Directors. The current committees are as follows:

Members of the Committees are chosen based on the interests and skills of individual Board members and the needs of the particular Committee. Most Committees meet three or four times per year, though a few (such as the Audit Committee) meet five or six times per year.

The Clinic and its regional hospitals maintain a governance model for the regional hospitals that provides for regional hospital representation on the Clinic's Board of Directors while also maintaining separate boards of trustees for each hospital. The regional hospital boards meet quarterly and, among other topics, provide local input on quality and patient safety and community health needs.

APPOINTMENTS

Linda McHugh was appointed Chief Human Resources Officer, succeeding Joe Cabral, who resigned in February 2016. Ms. McHugh previously served as the Executive Administrator for the Office of the CEO and Assistant Secretary for the Clinic since 2005. She served as part of the strategy team and played a role in advancing initiatives and programs that have resulted in operational efficiencies across the System.

Brian J. Harte, MD was appointed President of Cleveland Clinic Akron General and the Southern Region. Dr. Harte most recently served as President of Hillcrest Hospital and previously served as president of South Pointe Hospital. He also currently serves as the President of the Society of Hospital Medicine and is an associate professor of medicine in the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. The System has appointed an Interim President of Hillcrest Hospital while a search is conducted to identify a new president.

LAKEWOOD HOSPITAL ASSOCIATION

The Lakewood Hospital Association (LHA) is a non-obligated affiliate of the System. The Clinic, LHA and the City of Lakewood entered into an agreement in December 2015 that outlines the transition of healthcare services in the City of Lakewood and how the Clinic can be a leader in meeting those healthcare needs. Participation in the agreement by the City of Lakewood was authorized by an ordinance adopted by Lakewood City Council. Under the terms of the agreement, the Clinic and LHA will make contributions over the next seventeen years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Clinic will construct, own and operate an approximately 62,000-square-foot family health center expected to open in 2018 that will be located adjacent to the current site of the hospital. LHA ceased inpatient operations at the hospital in February 2016, while the emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The Lakewood Hospital site is currently leased by LHA from the City of Lakewood, and clinical services at that location are operated by the Clinic since the cessation of inpatient operations. The lease has been amended and is expected to terminate approximately thirty days after the opening of the family health center and emergency department. The Clinic has provided every Lakewood Hospital employee who wants a job with an employment opportunity within the System or at one of its partner organizations.

Prior to the signing of the agreement, a lawsuit was filed against the Clinic, LHA, the City of Lakewood and others (Defendants) by a few Lakewood residents (Plaintiffs) seeking to stop the closure of the hospital and money damages. To date, the court has denied the Plaintiffs' Motion for a Temporary Restraining Order. The Plaintiffs' Motion for a Preliminary Injunction is still pending. The Defendants jointly filed Motions to Dismiss the lawsuit. In November 2015, Lakewood voters defeated a proposed charter amendment that would have required voter approval on any Lakewood City Council ordinance that would have caused the hospital to no longer be a full time and full service hospital. As a result of duly signed petitions, a referendum vote to repeal the ordinance occurred in November 2016. The results upheld the ordinance adopted by Lakewood City Council.

Cleveland, Ohio Skyline

EXPANSION AND IMPROVEMENT PROJECTS

Due to the anticipated long-term growth in the demand for services and the desire to continually upgrade medical facilities, the System is investing in buildings, equipment and technology to better serve its patients.

The System has the following expansion and improvement projects currently in progress or recently completed:

Radiology Master Plan - This multi-year, five-phase renovation and construction plan is aimed at fulfilling the growth needs of the Department of Radiology within the Imaging Institute. The project will consolidate and centralize magnetic resonance (MR) services for the Clinic in the Glickman Tower located on the Clinic's main campus. The project also includes the renovation of vacated molecular functional imaging space into a new Computed Tomography (CT) department including sub-waiting, prep, changing, and hydration. Additionally, the plan allows for a new outpatient entrance to the Department of Radiology and enhanced patient waiting and changing areas. Phase 1A of the project, the Interventional MR Surgical Suite, began in 2009 and was completed in 2010. The Suite combines high-field MR imaging with a surgical suite, which allows surgeons to take advantage of MR imaging in real time during surgical procedures. Phase 1B, the consolidation of MR services in the Glickman Tower, began in the fourth quarter 2010 and was completed in July 2011. Phase 2, the consolidation of CT services, was completed in the third quarter of 2013. Phase 3, the relocation and upgrade of the Interventional Radiology Department, began in the third quarter of 2013 and was completed in the first quarter of 2015. Phase 4 began in the fourth quarter of 2015, and phase 5 began in the fourth quarter of 2016. These phases include thirty hard-walled and ten curtained holding rooms, a preparation and recovery area with 20 bed spaces that opened in July, a newly renovated ultrasound department that includes adult and pediatric scanning that opened in October, a state of the art myelogram room, gastrointestinal department and general diagnostic departments with sub-waiting and changing areas. The entire project is expected to be completed in 2018 with a total estimated cost of approximately $86 million.

Avon Hospital – In 2013, the System started design of a hospital to be located adjacent to the existing Family Health Center in Avon. The expansion includes an approximately 221,500 square foot five-story facility with 126 beds. The facility is being designed to leverage the latest in wireless capabilities and serve as a test site for evaluating future advancements in patient care. The estimated cost of the new hospital is $160 million. Construction started in the second quarter of 2014 and was completed in the fourth quarter of 2016. The new facility opened on November 15, 2016 and was named "The Roseann Park Family Tower."

New Cancer Outpatient Building – In 2013, the System started programming and design of a new Cancer Outpatient Building. The new building is located on the Clinic's main campus, adjacent to the Crile Outpatient Building and across from the new Tomsich

Pathology Laboratories Building. The 377,000 square foot, seven-story building is expected to house 126 exam rooms, 98 infusion bays, 6 linear accelerators, 7 procedure rooms, a Gamma Knife and other support functions for the Clinic's cancer program. The building will unite multidisciplinary surgical, medical, and support services for cancer at the main campus in one facility. The estimated cost of the new building is $276 million. Construction started in the third quarter of 2014 and is expected to be completed in the first quarter of 2017.

Main Campus Structured Parking Garage – With the anticipated increase in patient services provided by the new Cancer Outpatient Building, the System began design in 2014 of a 3,000 space structured parking garage to be located on the southeast corner of the main campus. The garage will be exclusively for employees, allowing current employee parking to be designated for patients and visitors. A pedestrian bridge will connect the garage to the Clinic's facilities. The garage and connecting bridge are expected to cost approximately $49 million. The garage opened in November 2016, and the pedestrian bridge is expected to be completed in the second quarter of 2017.

Enterprise Administrative Patient Management - The System is currently in the midst of a multi-year project to align revenue cycle support services and processes to support patients as they progress through their continuum of care. The Enterprise Administrative Patient Management (EAPM) project will consolidate thirteen different technology systems used for scheduling appointments, admissions, electronic medical records, billing and collections into one technology platform with the goal of improving patient experiences. Reducing the number of systems will improve patient service and employee efficiency. Implementation of EAPM began in the first quarter of 2012 at the System facilities in Weston, Florida. The Clinic's main campus and family health centers implemented EAPM in the first quarter of 2016. Implementation will continue in phases for the other System hospitals over the next several years and is expected to cost approximately $191 million over the entire implementation period.

Weston Hospital Expansion – In 2015, the System started design on expansion of Weston Hospital. The expansion will include a new tower hosting a 40-bed emergency department, a 24-bed observation unit, 26 acute care beds and 48 intensive care beds, including 23 relocated from the existing hospital. The new tower will also include a shelled floor for future expansion. To support this growth, significant renovation and backfill is planned to increase the size of existing imaging, laboratory, pharmacy, sterile processing and food services. A new endoscopy suite and three new operating rooms are also included in the renovation and backfill. The project includes a new central utility plant and new surface parking to support the campus expansion. The project is expected to cost approximately $230 million and be completed in late 2018.

Coral Springs Family Health Center and Surgery Center - Cleveland Clinic Florida is expecting to expand its services in a new Family Health Center and Surgery Center that will be built on land previously purchased in Coral Springs, Florida. Coral Springs is approximately twenty miles northeast of the Weston campus. This new 74,000 square

foot facility will accommodate approximately forty exam rooms, four operating rooms with shell space for two additional operating rooms in the future, two endoscopy rooms and imaging services. The full scope and cost for the facility have not been finalized. Design began in the second quarter of 2016, and construction is projected to be completed in the second quarter of 2018.

Akron General Emergency Department – In 2015, Akron General Medical Center began site preparations for a two-story, 73,000 square foot emergency department that will triple the size of the current space. The first floor will house the emergency department, and the second floor will contain administrative offices and potential space for expansion. The facility will have eight triage rooms and 39 treatment rooms for patients, including six high-acuity trauma rooms, an area designated for patients seeking treatment for sexual assault, an expanded behavioral health unit, an imaging department, a separate urgent care area, and an area for quarantining and treating highly contagious patients. The facility is expected to cost approximately $49 million. Construction of the building is scheduled to begin in the second quarter of 2017 and is expected to be completed in third quarter of 2018.

Lakewood Family Health Center – In January 2016, the Clinic started design of a new approximately 62,000 square foot, three story family health center in Lakewood on a site adjacent to the recently closed Lakewood Hospital. The facility will have an emergency department located on the first floor with 18 treatment rooms. On the second and third floors, the facility will have 58 exam rooms. There will also be lab and imaging services to support operations at the facility. The facility is projected to cost approximately $37 million and is scheduled to open in June 2018.

Health Education Campus - In the second quarter of 2013, the Clinic and Case Western Reserve University (CWRU) School of Medicine reached an agreement to build a health education campus that will contain CWRU's medical school program and the Cleveland Clinic Lerner College of Medicine. The campus includes a facility that will be located on the Clinic's main campus and will serve as home for the seminar, lecture, and laboratory curriculum taught during the first two years of medical school. Students' clinical training will continue to take place at area hospitals. This initiative is aligned with the future plans of the Clinic's main campus and supports the Clinic's mission and strategic direction. The facility will also house the CWRU Nursing School and School of Dental Medicine. The facility is designed to encourage extensive interaction and collaboration among the professions. Construction of the facility broke ground on October 1, 2015 and is expected to take approximately four years to complete. CWRU and the Clinic will share in the construction costs of approximately $453 million and the ongoing operational costs of the facility, with a portion of the construction costs expected to be raised through fundraising efforts and donations. Plans also include a separate dental clinic that will be adjacent to the medical school facility. The dental clinic is expected to open at the same time as the medical school.

PHILANTHROPY CAMPAIGN

The Clinic publicly launched "The Power of Every One" philanthropic campaign in June 2014 with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the Clinic to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. As of September 30, 2016, the Clinic has raised almost $984 million toward the goal.

The $2 billion campaign is divided into four categories: promoting health ($800 million), advancing discovery ($700 million), training caregivers ($400 million) and transforming care ($100 million). Promoting health will focus on improving patient experience and supporting construction and renovation projects, including the new Avon Hospital, new cancer and neurology buildings at the Clinic, renovation of the Taussig Cancer Institute building, new facilities in Florida and other building projects at regional hospitals and family health centers. Training caregivers will support scholarships, training programs and the construction of the new health education campus, a collaboration with CWRU. Advancing discovery will support translational, basic science and clinical research as well as endowed chairs. Transforming care will support the development of new care delivery models, personalized therapies and information technology.

INNOVATIONS

Cleveland Clinic Innovations promotes scientific, clinical and administrative creativity throughout the System and seeks commercial application of the products of that creativity. Specifically, it helps to grow the Clinic's innovative capacity, mentors inventors, licenses technology, secures resources, and establishes spin-off companies and strategic collaborations with corporate partners. Since 2000, Cleveland Clinic Innovations has launched 76 companies, transacted more than 450 technology licenses, filed over 2,900 patent applications with over 850 issued patents, and acted on approximately 3,600 new inventions.

Cleveland Clinic Innovations operates a 50,000-square-foot Global Cardiovascular Innovation Center (GCIC) on the Clinic's main campus, which is home to its operations, as well as an incubator facility for approximately 20 companies.

Cleveland Clinic Innovations manages the "Healthcare Innovations Alliance", a collaborative network of healthcare systems, academic institutions and industry partners from around the nation. Alliance partners utilize the Clinic's comprehensive technology and commercialization experience to turn medical ideas into marketable inventions and commercial ventures. The integration of capabilities between organizations is focused on discovery, development and rapid deployment of new technologies with the goal of improving patient care.

In January 2016, through the efforts of Cleveland Clinic Innovations, spin-off Tatara Vascular LLC received 510(k) approval from the Food and Drug Administration (FDA) to market a coronary guidewire invented by Patrick Whitlow, MD from the Heart & Vascular Institute. The approval

marks the first time Cleveland Clinic Innovations has facilitated FDA approval to market a technology in its portfolio.

In June 2016, Cleveland Clinic Innovations executed a license with a national patient experience services company to distribute and implement the Clinic's Communicate with H.E.A.R.T.® program to hospitals looking to improve their patient experience. The program, created and launched at the Clinic in 2010, has played a significant role in transforming the Clinic's culture to utilize patient centric approaches in all care and service interactions.

Funded by the State of Ohio, and managed by Cleveland Clinic Innovations, the GCIC concluded its 16th Commercialization Funding Program selection process in August 2016 making project development awards to three Ohio-based companies totaling $1.2 million. Since inception in 2007, the program has funded a total of 51 projects totaling $21 million to companies that have created over 1,060 jobs in Ohio and secured over $937 million in follow-on funding.

Cleveland Clinic Innovations hosts an annual Medical Innovation Summit for industry leaders, investors, and entrepreneurs looking to expand their understanding of the healthcare market and the future of medical innovation. The 14th Annual Medical Innovation Summit was held in October 2016 with over 2,250 attendees to discuss investable innovations in the context of healthcare's historic transformation. Vice President Joe Biden kicked off the three-day summit with a speech about the Cancer Moonshot and the critical need to give hope and time to cancer patients with new treatments and innovations. Other keynote addresses were delivered by Joe Almeida, Chairman & CEO of Baxter; Omar Ishrak, Chairman & CEO of Medtronic; Ian Read, Chairman & CEO of Pfizer; and Mike Musallem, Chairman & CEO of Edwards Lifesciences.

The Summit also unveiled the Top 10 Medical Innovations of 2017, which highlighted the potential for medical breakthroughs in the coming year. Products that harness the power of the microbiome to prevent and treat disease were ranked as the number one innovation by a distinguished panel of Clinic doctors and researchers.

CLINICAL AFFILIATIONS

The Clinic has entered into various affiliations with national and regional partners that are seeking to improve clinical quality, patient care, medical education and research. The goal of clinical affiliations is to provide value-added, high quality clinical care to patients through the support, expansion and development of Institute-driven integrated care strategies. In addition, the Clinic has partnered with educational institutions with the goal of improving medical education and research.

In April 2016, the Clinic's Sydell and Arnold Miller Family Heart and Vascular Institute entered into an affiliation with Froedtert & the Medical College of Wisconsin Froedtert Hospital in Milwaukee, Wisconsin. The two organizations will remain independent but share best practices in patient care, outcomes measurement, quality reporting and clinical research. Physician teams from both entities will collaborate to accelerate advances in heart care treatments and protocols.

In August 2016, the Clinic's Endocrinology and Metabolism Institute entered into an affiliation

with the National Diabetes and Obesity Research Institute (NDORI) to enhance diabetes and obesity related research and discover better treatment protocols. This is the first affiliation for the Clinic's Endocrinology and Metabolism Institute. NDORI was founded in 2015 by a group of health care, education and business leaders in Mississippi with the hopes of finding a cure for diabetes. NDORI will be part of a 150-acre learning medical city located in Tradition, Mississippi. Once the affiliation is fully implemented, NDORI patients will have greater access to better practices related diabetes and obesity treatments.

In August 2016, the Clinic's Taussig Cancer Institute entered into an affiliation with ProMedica Health System in Toledo, Ohio. The affiliation is expected to expand access to highly-specialized cancer treatments, clinical expertise and research studies for patients in northwest Ohio and southeast Michigan, including a process that allows patients to get second opinion consults with Clinic cancer specialists. The first year of the affiliation will focus on sharing quality metrics, protocols, clinical pathways and best practices between the organizations as well as identifying opportunities to collaborate on clinical research and provide expanded education and training.

STRATEGIC ALLIANCES

In April 2016, the Clinic announced a partnership with CVS, a national drugstore chain that offers MinuteClinics. MinuteClinics treat common family ailments in addition to performing various health screenings, pregnancy tests, suture removal and vaccinations. With the new partnership, a MinuteClinic patient who needs further consultation can access a primary care practitioner from the Clinic within five to ten minutes during working hours via "telemedicine" or "telehealth." Examples of telemedicine include primary care by videoconference, as well as remote monitoring of patients via wearable technology and providing medical education to practitioners. CVS and the Clinic are working with American Well, one of the nation's largest telehealth companies, to provide the technology that will be used in MinuteClinics.

JOINT VENTURE

Under a joint venture agreement with Select Medical, the Cleveland Clinic Rehabilitation Hospital opened in December 2015 in Avon, Ohio. Select Medical is the nation's largest provider of post-acute care services and has partnerships with academic medical centers around the country. The Clinic is a minority member in the joint venture. The new 68,000 square foot facility has 60 beds and features private rooms and the latest rehabilitation equipment to care for patients with stroke, spinal cord injury, brain injury, and a variety of medical and surgical conditions. The facility expands inpatient rehabilitation services in Northeast Ohio and improves access for patients with complex rehabilitation needs. The hospital will also serve as a primary teaching site for a new residency program for physicians in physical medicine and rehabilitation.

In March 2016, the Clinic and Select Medical announced a proposal to build two new rehabilitation facilities in Northeast Ohio - one in Bath Township and one in the City of Beachwood. Each facility is expected to have 60 beds and take approximately 18 months to complete once approved.

In July 2016, the Clinic entered into a joint venture agreement with Select Medical to operate four long-term acute care (LTAC) facilities in northeast Ohio with a total of 230 beds. The Clinic is a minority member in the joint venture. The joint venture expands the current existing relationship with Select Medical and is expected to combine the experience of both organizations in the treatment of LTAC patients.

AKRON GENERAL HEALTH SYSTEM

In November 2015, the System became the sole member of Akron General Health System (Akron General), an integrated healthcare delivery system with a 532-registered bed flagship medical center located in Akron, Ohio. In addition to the flagship medical center, Akron General also includes Lodi Community Hospital, Edwin Shaw Rehabilitation Institute, three health and wellness centers, Visiting Nurse Services and affiliates, a physician group practice and other outpatient locations. The System previously had a 35% special membership interest in Akron General pursuant to an affiliation agreement effective in September 2014 that included a $100 million capital investment in Akron General. An option to take full ownership of Akron General was exercised after the one-year anniversary of the affiliation agreement due to the successful collaboration that had occurred between the Clinic and Akron General on a number of initiatives. These initiatives resulted in clinical expansion, cost savings, and best practice sharing. The full member substitution became effective following review of the transaction by the Ohio Attorney General and the Federal Trade Commission. As part of the member substitution agreement, the Clinic and Akron General have committed to additional funding for the capital expenditure needs to support Akron General's capital plan for the next five years. Future initiatives include a new emergency department at Akron General Medical Center, two new outpatient centers in the surrounding Akron area and replacement of Akron General's electronic medical records system to enhance safety, quality, and patient experience and reduce the overall cost of care.

As part of integration efforts involving Akron General and through review of contractual relationships between Akron General and some of its independent physician practice groups, the Clinic identified possible violations to the Federal Anti-Kickback and Limitations on Certain Physician Referrals (commonly referred to as the "Stark Law"), which may have resulted in false claims to federal and/or state health care programs and may result in liability under the False Claims Act. Akron General is communicating such possible violations to the appropriate government authorities. There is a probable contingent liability associated with the matters described above, which may put at risk federal reimbursements related to services provided to patients at Akron General by the practice groups. It is not possible to estimate the amount of contingent liability at this time and therefore no amount has been recognized in the consolidated financial statements.

In addition, as a large community hospital, Akron General in the normal course has received information or identified issues regarding various billing, coding and related compliance matters. However, aside from the matters described in the paragraph above, Akron General is not aware of any current matters that would have a material impact on its business or operations.

INTERNATIONAL GROWTH

In October 2015, the Clinic through a subsidiary acquired all of the share capital of 33 Grosvenor Place Limited (Grosvenor Place). Grosvenor Place is a limited liability company existing under Luxembourg law and a private company incorporated under Jersey law that has a long-term leasehold interest in a six-story 198,000 square-foot building in London, England. The Clinic has established a plan to convert the building from office space to a healthcare facility upon receiving the necessary approvals from local authorities. Various tenants have vacated the facility, and the facility is expected to be fully vacated in the first quarter of 2017.

In addition to the London project, the System internationally operates a health and wellness center in Toronto, Canada and provides management services to two hospitals in Abu Dhabi.

STRATEGY

The U.S. healthcare industry is undergoing unprecedented change with the intersection of economic pressure, insurance reform, technological breakthroughs, and demographic shifts. At the center of this change is an accelerating shift in reimbursement models from volume- to value-based and/or risk-based payment. Maximizing attributed lives where patients bring an entirely new level of consumerism is of paramount importance in this emerging environment. The System is well engaged in this shift with nearly 500,000 lives from Northeast Ohio and Florida under some form of risk-based contract in 2017. Naturally, this dynamic landscape has and continues to influence how the System shapes its path forward.

In 2013, the System set forth a strategy to embrace these fundamental shifts and position the organization for continued leadership and success in meeting its mission and goals in a vastly changing environment. The strategy focuses on the principle of Patients First and contains the following themes designed to transform value and provide for continued growth:

- Continue to thrive as a global referral center for the most complex care
- Master community-based care in a framework of population management
- Innovate medical education to prepare the next generation who are relevant to the changing environment
- Leverage and extend the unique assets and capabilities of the System to grow and diversify the revenue base and to solidify connectivity with other referral sources

The organization has been pursuing a roadmap of transformation referred to as the Strategic Agenda. The Strategic Agenda calls for fundamental changes in the System's care, operating and business models over several years. The specific roadmap is guided by the strategy and five overarching goals:

Patients First	– continuously improve quality, safety and patient experience
Caregivers	– make the System the best place to work
Affordability	– steward resources
Growth	– responsibly develop to sustain our mission
Impact	– make a difference through research, education and innovation

The centerpiece of the Strategic Agenda is a set of key performance indicators and priority initiatives established by leadership and formalized in a strategic agenda management (SAM) system. The purpose of the SAM is to enable leadership to systematically translate the strategy and goals to the priority work of the enterprise. The goal of the SAM is that ultimately every clinical and non-clinical area and every individual caregiver will work to align their respective efforts and initiatives to the organization's highest priorities.

In parallel with efforts to transform the care model, the System is redefining its relationships with payors/employers and the payment system to match the broader industry trend toward risk-shifting and redesigned payment. The goal of these efforts is to better deliver to the changing demands of payors/employers, while preserving the financial security of the system during the transition. This involves increased forms of risk-taking in payor contracts (from pay-for-value to bundled payment to shared savings) and narrow network arrangements with payor partners.

As a major element of delivering value, an important thread through all of the priority initiatives of the clinical enterprise is care affordability – reducing the cost structure so that the System can be price competitive and render care more affordable for patients. In 2013, the System commissioned a Care Affordability Task Force to perform an enterprise-wide cost structure analysis and propose recommendations for transformational cost and efficiency opportunities. The organization is mobilized to systematically scrutinize its use of resources in all clinical, operational and administrative areas. This work is expected to be an ongoing effort year over year.

The System's caregivers continue to identify and pursue ways to improve on every dimension of the organization's performance: relentless pursuit of quality and safety, how care is organized and delivered, how research and education are effectuated, and how the organization's value is conveyed to the market. The System is committed to a path not only to respond to the changes in the environment, but also to lead the field with novel approaches that preserve excellence in care while offering sustainable models for others to adopt.

COMMUNITY BENEFIT AND ECONOMIC IMPACT

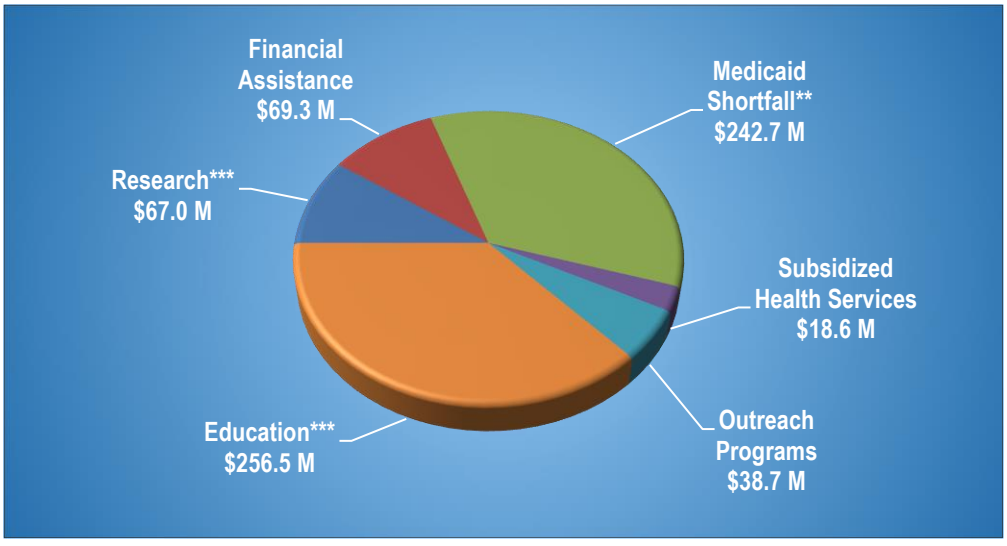
Community Benefit

The Clinic and its hospital affiliates within the System are comprised of charitable, tax-exempt healthcare organizations. The System's mission includes addressing health service needs and providing benefits to the communities it serves. The tax-exempt members of the System must satisfy a community benefit standard to maintain tax-exempt status. Community benefit reporting for the System conforms to Internal Revenue Service requirements.

Community benefit includes activities or programs that improve access to health services, enhance public health, advance generalizable knowledge and relieve government burden. The primary categories for assessing community benefit include financial assistance, Medicaid shortfall, subsidized health services, outreach programs, education and research.

In 2015, the System provided $692.8 million in benefits to the communities it serves. The following chart summarizes community benefits for the System:

Cleveland Clinic Health System*
Breakdown of Community Benefit (2015)
$692.8 Million



* Includes all System operations in Ohio, Florida and Nevada, and includes Akron General for the full year of 2015
** Net of Hospital Care Assurance Program benefit of $12.3 million
*** Research and Education are reported net of externally sponsored funding of $144.3 million.

Financial Assistance: Financial Assistance represents the cost of providing free or discounted medically necessary care to patients unable to pay some or all of their medical bills. The System's financial assistance policy provides free or discounted care to uninsured patients with incomes up to 400 percent of the federal poverty level and who meet certain other eligibility criteria by state. This policy covers both hospital care and services provided by the System's employed physicians. As a result of the Affordable Care Act implementation, which requires individuals to obtain healthcare insurance, nonprofit hospitals across the United States saw an increase of individuals covered by Medicaid or health exchange policies. With more persons covered under such programs, there was a decline in the number of patients seeking financial assistance.

Medicaid Shortfall: The System is a leading provider of Medicaid services in Ohio. The Medicaid program provides healthcare coverage for low-income families and individuals and is funded by both the state and federal governments. Medicaid shortfall represents the difference between the costs of providing care to Medicaid beneficiaries and the reimbursement received by the System. Due primarily to the effects of Medicaid expansion in Ohio, the Medicaid Shortfall in 2015 increased, providing more services to more patients.

Subsidized Health Services: Subsidized health services yield low or negative margins, but these programs are needed in the community. Subsidized health services provided in the System include pediatric programs, psychiatric/behavioral health programs, obstetrical services, chronic disease management and outpatient clinics.

Outreach Programs: The System is actively engaged in a broad array of community outreach programs, including numerous initiatives designed to serve vulnerable and at-risk populations in the community. Outreach programs typically fall into three categories: community health services; cash and in-kind donations; and community building. The System's outreach programs include wellness initiatives, chronic disease management, clinical services, free health screenings, and enrollment assistance for government funded health programs. A few of the System's community outreach initiatives are highlighted below:

- The System provided no-cost clinical care to under- and uninsured families at community sites. For example, the Langston Hughes Health and Education Center, a Fairfax neighborhood site, provided multigenerational prevention and wellness services.
- Health fairs provided thousands of people with free screenings for diabetes, cholesterol, heart disease, and prostate and various cancers. The Cleveland Clinic Minority Men's Health Fair, Celebrating Sisterhood, Tu Familia and dozens of other community health fairs educated community members on the benefits of preventive healthcare.
- Community education classes were offered across the enterprise on chronic disease management in the areas of heart disease, stroke, cancer, diabetes and brain health.
- Wellness initiatives and health lectures were provided to schools, faith-based organizations and community centers in the areas of prevention and behavioral change, including smoking cessation, weight management, teen parenting, family violence and child safety.

- Physical education, training and concussion awareness were provided to high school students by the Clinic's Orthopaedic and Rheumatology Institute. The Pediatric Mobile Unit provided wellness services to local elementary schools.
- The Clinic's Robert J. Tomsich Pathology & Laboratory Medicine Institute donated services to The Free Clinic and Care Alliance, Cleveland area safety-net providers.

Education: The System provides a wide range of high-quality medical education, including accredited training programs for residents, physicians, nurses and other allied health professionals. The System maintains one of the largest graduate medical education programs in the nation. At the postgraduate level, the System's Center of Continuing Education has developed one of the largest and most diverse continuing medical education programs in the world. The System also operates Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, dedicated to the teaching of physician-scientists.

Research: From a community benefit perspective, medical research includes basic, clinical and community health research, as well as studies on healthcare delivery. Community benefits include research activities supported by government and foundation sources; corporate and other grants are excluded from community benefits. The System uses internal funding to cover shortfalls in outside resources for research.

Additional information regarding the System's community benefits is available on the Clinic's website at *www.clevelandclinic.org/communitybenefit*.

Community Health Needs Assessment

In 2013, the System completed comprehensive community health needs assessments (CHNA) for each of the hospitals in the System that are required to complete an assessment. Internal Revenue Code Section 501(r)(3) requires nonprofit hospital organizations to conduct a CHNA every three years and adopt an implementation strategy to identify the community health needs the hospital will address. The System is updating and conducting a CHNA in 2016 for each of the hospitals in the System that are required to complete an assessment.

To obtain an in-depth understanding of the community risk indicators, population trends and healthcare needs, the System has gathered and will gather various data, including:

- demographic and health statistical data;
- information on socio-economic barriers to care, including income, culture, language, education, insurance and housing;
- national, state and local disease prevalence;
- health behavior;
- penetrating trauma rates; and
- research and education.

Information has and will be gathered from persons representing the broad interests of the community, including those with special knowledge or expertise in public health.
Key CHNA needs identified throughout the System include:

- chronic disease management (heart disease, cancer, diabetes, asthma, obesity);
- wellness (nutrition, exercise, tobacco cessation, preventative care);
- access to care;
- education (physician shortage, community education); and
- medical research.

Hospital implementation strategies that address the health needs identified in the assessments were developed by individual hospital leadership teams and were adopted by the applicable boards in 2013. The CHNA reports and implementation strategies for the System hospitals are available on the Clinic's website.

Economic Impact

According to the System's Economic and Fiscal Impact Report released in 2015, the System is the largest employer in Northeast Ohio and the second largest employer in the State of Ohio. In 2013 the System generated $12.6 billion of the total economic activity in Ohio and has directly and indirectly supported more than 93,000 jobs generating approximately $5.9 billion in wages and earnings. The System's economic activity was accountable for $811 million in total state and local taxes. System-supported households spent almost $4 billion on goods and services. Locally, the System's economic activity within an eight-county region accounted for approximately $757 million of purchased good and services from Northeast Ohio vendors. Visitors to the System's Northeast Ohio facilities spent close to $191 million on hotels, food and other expenses. As a major part of the region's healthcare industry, the System has contributed to the strengthening of Ohio's economy by sustaining a strong workforce and supporting businesses and professional services across the state.

The System's Economic and Fiscal Impact Report is the result of an economic analysis completed by the Silverlode Consulting Corp. The most recent report was commissioned in 2014 and used 2013 data, the most current data available at that time. The report was completed in part using the IMPLAN® economic impact model, which is used by more than 1,000 universities and government agencies to estimate economic and fiscal impacts.

SUSTAINABILITY

The System supports healthy environments for healthy communities, recognizes the link between environmental and human health and strives to responsibly address and mitigate its environmental impacts. As a national leader in healthcare, the System is in a position to lead by example in the adoption of environmental best practices. With a built environment portfolio of more than 22 million square feet and more than 49,000 caregivers, the impact of the System on the community and ecosystem, both positive and negative, is substantial.

The System's Office for a Healthy Environment (OHE) acknowledges its obligation and opportunity to minimize the health impacts of climate change. The System is working to enhance the resilience of its facilities and communities, engaging its stakeholders to personalize climate action and embedding sustainability into its healthcare delivery model.

As a leader in the healthcare industry, the System has publically committed to compiling an annual sustainability report for its patients, caregivers, communities and global stakeholders through two leading international frameworks: The United Nations Global Compact and the Global Reporting Initiative. The compilation, titled "Serving Our Present, Caring for Our Future," includes performance metrics and stories, highlights accomplishments and communicates challenges as the System strives to reach its goals. The complete report is available at: *www.clevelandclinic.org/ungc*.

In October 2015, the Clinic was recognized by Becker's *Hospital Review* as one of the 50 greenest hospitals in America. Hospitals on the list were selected based on a number of factors, including their sustainability efforts and commitment to the Healthier Hospitals Initiative as well as awards received from the Environmental Protection Agency and Practice Greenhealth.

The Clinic is a member of Practice Greenhealth (PGH), the nation's leading health care community that empowers its members to increase their efficiencies and environmental stewardship while improving patient safety and care through tools, best practices and knowledge. In 2016, the Clinic was awarded the prestigious "Greening the OR" environmental achievement award offered by Practice Greenhealth. The award is given to only one healthcare system in the country for its performance in energy efficiency, materials efficiency and recycling in the operating room. The Clinic also won two Top 25 Environmental Excellence Awards for Best of Sustainability in Health Care designation at the Clinic and Marymount Hospital. The Top 25 Environmental Excellence Awards recognize health care facilities that exemplify environmental excellence and are setting the highest standards for environmental practices in health care. Award winners are chosen from hospitals that have the highest scores using Practice Greenhealth's thorough scoring and evaluation system. The System was honored with twenty-seven additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in health care sustainability, including the System for Change Award, two Emerald Awards for Euclid Hospital and Strongsville Family Health Center, Circles of Excellence in Sustainability Leadership, Environmentally Preferred Purchasing, Chemicals, Greening the OR, Green Building and Climate.

In April 2016, the Clinic received the Environmental Protection Agency's Energy Star Partner of the Year award for its leadership in energy demand reduction and environmental health promotion. This award was granted to less than 1% of the 16,000 participants, and only two organizations in the healthcare industry received this award in 2016.

In July 2016, the Clinic joined Solar.Clinic, a program that will help health care systems to use solar energy and offer solar energy to their employees, patients, and community members with the goal of reducing the environmental impact of practicing medicine. The program is newly launched by Geostellar, an online solar marketplace that provides an online support system for distributing and deploying solar energy.

The System's energy program is designed to enhance patient outcomes and the patient

experience while reducing operating expenses. As the model of healthcare evolves, the System is committed to reducing environmental, economic and human impact by reducing energy intensity. The System's commitments to both affordable care and external partnerships with ENERGY STAR and the Better Buildings Challenge have created goals of becoming 20% more energy efficient by 2020 from a 2010 baseline on more than 20 million square feet of facilities. Initiatives include a combination of critical energy efficiency projects and broad occupant education and engagement campaigns. From the December 2010 baseline, the System has realized a 13% reduction in weather normalized source energy use intensity for in-scope and reportable facilities.

In May 2016, the Clinic announced the establishment of a $7.5 million Green Revolving Fund (GRF), which is the largest established fund of its kind in the healthcare industry and one of the largest in any business sector nationally. GRF funds invest in energy efficiency projects to reduce energy consumption. Savings achieved from reduced energy consumption and any rebates received are tracked and used to replenish the GRF fund to invest in future projects. The establishment of the GRF fund is part of the Sustainable Endowments Institute's Billion Dollar Green Challenge. The challenge encourages colleges, universities and other nonprofit institutions to invest in self-managed green revolving funds. The Clinic's GRF fund will help drive the Clinic's continued commitment to energy conservation and overall sustainability, including the goals set forth by the Better Buildings Challenge.

A central component of the Systems' ongoing commitment to responsible energy management is to construct buildings that conform to the U.S. Green Building Council's Leadership in Energy and Environmental Design (LEED). LEED is a third-party certification program and the nationally accepted benchmark for design, construction and operation of environmentally responsible and energy-efficient buildings. All new major construction projects for the System follow LEED standards, with a goal of achieving silver certification. Construction projects also emphasize recycling of debris, with current diversion rates of up to 98% in recent years.

The System currently has fifteen LEED-certified buildings, with additional buildings pending certification. The System has four buildings that are certified LEED-Gold, including the Global Cardiovascular Innovations Center, Marymount Hospital Surgical Expansion, Twinsburg Health and Family Surgery Center and the Tomsich Pathology Laboratories building. Additionally, the System has seven buildings that are certified LEED-Silver.

DIVERSITY

The System provides healthcare services to patients and families from a global community. This makes diversity, inclusion and cultural competence a critical part of the System's mission. In 2006, the System created the Office of Diversity and Inclusion (Diversity). Diversity's mission is to provide strategic direction that builds cultural competence, cultivates an inclusive organization, develops talent, and supports caregivers to better serve our patients. Its programs include cultural competence training, diversity councils, employee resource groups, language enrichment, and pipeline development programs for high school and college students.

The System was awarded the American Hospital Association's Equity of Care Award for 2016.

Presented annually, this recognition honors hospital systems that have achieved a high level of success in reducing healthcare disparities while promoting diversity throughout the organization. Also in 2016, the System was ranked number two on the list of the country's top ten healthcare organizations for diversity management practices by DiversityInc. The System has made this list for the seventh consecutive year. Rankings are empirically driven and assess performance based on a number of factors including CEO commitment, equitable talent development, talent pipeline and supplier diversity.

The System received the 2016 Leader in LGBT Healthcare Equality recognition. This recognition is based on the Healthcare Equality Index, which is a benchmarking tool that evaluates healthcare facilities for equity and inclusion of lesbian, gay, bisexual and transgender patients, visitors and employees. This is the second consecutive year that the System has received this recognition.

Three of the System's Employee Resource Groups (ERGs) were ranked among the top 25 nationwide by the Association of ERGs & Councils. The African American ERG placed 1st, ClinicPride placed 12th, and SALUD placed 22nd. ERGs are in place to increase the awareness of the patients' diverse healthcare needs, make our system more culturally competent, and give caregivers the opportunity to network with others from similar backgrounds and receive exposure to career development opportunities.

HEALTH INFORMATION TECHNOLOGY

The System is a national leader in the innovative application of health information technology (HIT) systems. Through the development and application of HIT systems, the System is focusing on providing more cost effective healthcare and improving patient safety. HIT systems have received particular attention due to the Health Information Technology for Economic and Clinical Health Act, a part of the American Recovery and Reinvestment Act of 2009 (Recovery Act).

In 2011, the Centers for Medicare & Medicaid Services (CMS) implemented provisions of the Recovery Act that provide annual incentive payments for the meaningful use of certified electronic health record (EHR) technology. CMS has defined meaningful use as meeting certain objectives and clinical quality measures based on current and updated technology capabilities over predetermined reporting periods as established by CMS. The objectives and clinical quality measures are implemented in stages with increasing requirements for participation. CMS announced Stage 2 electronic health record meaningful use requirements in 2012, which added new objectives and increased the threshold for many of the objectives in Stage 1. In order to be reimbursed, System hospitals are required to meet Stage 2 meaningful use requirements. Further, modifications to the Stage 2 meaningful use requirements were established in 2015.

Currently, all of the System's acute care hospitals meet the Medicare meaningful use standards for attestation for modified Stage 2. Additionally, all of the System's acute care hospitals meet the Medicaid meaningful use standards for attestation for Stage 2 except for Weston Hospital, which currently does not qualify to participate in the Medicaid EHR incentive program. Cleveland Clinic Children's Hospital for Rehabilitation, a non-acute hospital located near the main campus, also meets the Medicaid meaningful use standards for attestation for

modified Stage 2. Edwin Shaw Hospital is a post-acute inpatient rehabilitation facility that does not qualify for meaningful use incentive payments.

Incentive payments for hospitals are subject to retrospective adjustments after the submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. Under meaningful use, annual incentive payments for Medicare and Medicaid are reduced for hospitals and providers in each subsequent year of attestation and are completely phased-out within four to six years of the initial attestation year.

Beginning in 2015, CMS updated the EHR incentive program reporting period with the modified stage 2 rules. The measurement for all hospitals is based on the calendar year. Attestations for the 2015 program year were accepted by CMS beginning January 4, 2016 for both eligible professionals and eligible hospitals.

The System utilizes a grant accounting model to recognize EHR incentive revenues. Under this model, the System records EHR incentive revenue ratably throughout the incentive reporting period when it is reasonably assured that it will meet the meaningful use objectives for the required reporting period and that the grants will be received. The System recorded EHR incentive revenues of $3.4 million for the nine months ended September 30, 2016 and has recorded a total of $143 million since the inception of the program. Throughout the program, the System is expected to receive approximately $146 million in EHR incentive payments.

The System continues to implement improvements to its HIT systems, including several components that can be accessed through the Clinic's website. These components include:

- An electronic medical record system composed of an integrated suite of software modules that virtually align physical locations, physician expertise and nursing and care team skills into a single, coordinated group practice.
- A secure, on-line health management tool that connects patients to portions of their personalized health information.
- A secure, on-line system that allows physicians in private practice to become clinically integrated with the System to treat their patients.

The System participates in the Care Everywhere network, a module offered through Epic Systems Corp. that allows health systems to safely and directly share electronic medical records (EMRs). Through this program, the System has access to hundreds of healthcare organizations nationwide. The System has exchanged over 6 million patient records with more than 870 hospitals, 1,090 emergency rooms, and 24,000 clinics to assist with treating patients in all fifty states across the country since the beginning of 2015. This is believed to have improved patient care by immediately providing more complete medical histories, eliminating the need for unnecessary diagnostic tests, allowing for faster and more accurate diagnosis and aiding in criteria required for Stage 2 meaningful use standards. The System collaborates with both local and national hospitals and health systems to link EMRs via Epic. Since 2013, the System engaged with ClinicSync, Ohio's statewide electronic medical records exchange. Participation in CliniSync links the System to a significant number of hospitals and physician practices across Ohio.

To further broaden its interoperability capabilities, the System has also engaged with

Surescripts, a health information service provider that connects the System to over 200,000 providers across the nation via DIRECT messaging. The System is also connected to eHealth Exchange, the national health exchange hub. This connection was implemented in the summer of 2014 and has allowed the System to exchange data with the Social Security Administration.

In 2015, the System connected its electronic medical system, MyPractice, to the Veterans' Administration (VA) electronic medical record system. The connection to the VA has had over 600 exchanges since implementation. This data exchange allows medical information of veteran patients to be securely shared and improves provider-to-provider communication between the Clinic and the VA.

CONFLICT OF INTEREST

The System maintains policies that require internal reporting of outside financial and fiduciary interests to ensure that potential conflicts of interests do not inappropriately influence research, patient care, education, business or professional decision making. In connection with these policies, the System developed the Innovation Management and Conflict of Interest Program, which is designed to promote innovation while at the same time reducing, eliminating or managing real or perceived bias either due to System personnel consulting with pharmaceutical, medical device and diagnostic companies (industry) or the commercialization efforts undertaken by the System to develop discoveries and make them accessible to patients. The Program works with investigators who interact with industry to manage any conflicts. Provisions related to whether or not "compelling circumstances" are required to justify conducting research in the presence of related financial interests have been modified in policies that went into effect in 2013, consistent with the value the System places on beneficial relationships with industry. The System is committed to a process that maintains integrity in innovation and places the interests of our patients first.

The Innovation Management and Conflict of Interest Program reviews situations in which a physician prescribes or uses products of a company in their practice and has a financial relationship with that company. When appropriate, the Program will put management in place to address any conflict (for example, by disclosure). The goal of this policy is not to interfere with the practice of medicine.

An initiative to bring transparency to the System's relationships with industry was implemented in 2008, in which the specific types of interactions that individual physicians and scientists have with industry were disclosed on publicly-accessible web pages on the System's internet site. Information can be accessed by patients that describes the training, type of practice and accomplishments of a specific doctor or scientist, as well as the names of companies with which the doctor has financial or fiduciary relations as an inventor, consultant, speaker or board member. These disclosures are updated regularly. The System was the first academic medical center in the country to have made these interactions public. Many other academic medical centers have followed the System's lead by providing similar disclosures.

The System maintains a Conflict of Interest in Education Policy to reflect its values and represent its and its Staff's best interests. This policy is responsive to guidelines from the Association of American Medical Colleges, the Institute of Medicine and other organizations. It

places restrictions on outside speaking activities that are not Accreditation Council for Continuing Medical Education approved and are generally considered marketing. Speakers must present content that is data-driven and balanced; speakers must create their own slides or use only unbranded slides created by industry. This policy puts the System in step with other top academic medical centers that have already banned speaker's bureaus. In addition, the policy requires instructors to disclose relevant financial interests with companies to trainees.

The Innovation Management and Conflict of Interest Committee of the System has also established processes with cross-membership and seamless interactions and communications with the Board of Directors' Conflict of Interest and Managing Innovations Committee.

Board members of the Clinic and the regional hospitals in the System are required to complete annual disclosure questionnaires each year. These questionnaires are designed to identify possible conflicts of interest that may exist and ensure that any such conflicts do not inappropriately influence the operations of the System. The information obtained from these questionnaires is used to respond to the related-party transactions and other disclosures required by the Internal Revenue Service on Form 990. The Forms 990 for the Clinic and the System are available on the Clinic's website, as well as additional information regarding the Clinic's Board of Directors and any business relationships the Directors may have with the System.

ENTERPRISE RISK MANAGEMENT

In 2010 the System began a multi-phase enterprise risk management (ERM) initiative to develop a more formal systematic approach to the identification, assessment, prioritization, and reporting of risks. The process is closely linked with the System's strategic and annual planning. The ultimate objective is to create an enterprise-wide risk management model that contains sustainable reporting and monitoring processes and embeds risk management into the System's culture, in order to more effectively mitigate risks. The System established an ERM Steering Committee and engaged a consulting firm to support this process.

In the ERM process, risk identification is conducted resulting in a System risk profile that categorizes individual risks based on their impact upon the System's ability to meet its strategic objectives. During this process, certain risks are identified as top risks and then further separated into sub-risks and individual risk components. Extensive risk assessments and mitigation analysis are prepared during this process whereby risk components are evaluated according to their likelihood of occurring and potential impact should they occur. Risk mitigation activities, including risk response effectiveness, are examined, reviewed and updated as part of this evaluation. The most recent comprehensive evaluation of top risks was concluded in the third quarter of 2016. ERM is an on-going program, with regular reporting to senior management, including the Audit Committee of the Board of Directors, the body with oversight responsibility for ERM.

INTERNAL CONTROLS OVER FINANCIAL REPORTING

The System regularly evaluates its internal control environment over the System's financial reporting processes through an initiative based upon concepts established in the Sarbanes-Oxley Act of 2002. The goals of the initiative are to ensure the integrity and reliability of financial information, strengthen internal control in the reporting process, reduce the risk of fraud and improve efficiencies in the financial reporting process. The initiative reviews all aspects of the financial reporting process, identifies potential risks and ensures that they have been mitigated utilizing a management self-assessment process. As a result of this initiative, management completed a certification of its internal controls over financial reporting as part of the issuance of its audited consolidated financial results for 2015, which is the seventh year the certification process was completed. The certification included 130 members of management, including top leadership. The System is one of the first not-for-profit hospitals to issue a management report on the effectiveness of internal controls over financial reporting, a step that further increases the transparency of the organization. Management updates the certification on a quarterly basis. There were no changes in internal controls over financial reporting during the nine months ended September 30, 2016 that have materially affected, or are likely to materially affect, the internal controls over financial reporting for the System.

INDUSTRY OUTLOOK

In December 2015, Moody's Investor Services (Moody's) maintained its stable outlook for the U.S. not-for-profit healthcare sector, an outlook Moody's revised from negative to stable in August 2015. To support its outlook, Moody's cites that operating cash flow growth remains strong following several years of little to no growth. Moody's expects the cash flow growth to return to normal levels of 3%-4% as patient volume growth eases and rates of insurance coverage stabilize. Another factor in Moody's rating is that bad debt continues to fall, although the rate is slowing as changes in healthcare insurance coverage are stabilizing. Moody's also notes that long-term risks and challenges related to investments in population health, consolidation among insurance companies, negative changes on health exchanges, and growing exposure to government insurance programs still remain a concern for the sector.

In February 2016, Standard & Poor's (S&P) maintained its stable outlook for the U.S. not-for-profit healthcare sector, an outlook S&P revised from negative to stable in September 2015. The S&P revision in September 2015 was based on the sector's improved financial performance and the positive impact of the Affordable Care Act on providers, including improvement in patient volume levels and payor mix and reduction in uncompensated care. Unrestricted liquidity positions that have been sustained or improved over the last year have also supported their revision. S&P noted the sector still has challenges, which include uncertainty on multiple fronts and the expectation of longer term revenue pressures.

The System continues to be impacted by industry challenges that put pressure on the System's financial performance. Management is focused

on the recruitment and retention of qualified staff in many clinical areas in order to meet the demands of patient activity, particularly as the Affordable Care Act health insurance mandates and Medicaid expansion programs have been implemented that have increased the number of insured Americans seeking healthcare services. These efforts pressure the System's salary cost structure, as well as employee benefit costs. Pharmaceutical costs and medical supply costs continue to create challenges to the cost structure. Increases in pharmaceutical costs are driven by utilization, price increases and the specialized nature of many pharmaceuticals used in oncology and hematology. Medical supply costs are primarily driven by utilization and price of implants. For both pharmaceuticals and medical supplies, a sizeable percentage of the cost increase flows through to increases in payments from payors; however, the balance cannot be passed through to payors. Additionally, the healthcare industry is subject to significant regulation by federal, state, and local governmental agencies and independent organizations and accrediting bodies, changes in technology and treatment modes, competition and changes in third-party reimbursement programs. The decline in the population of the Greater Cleveland area, as noted in recent estimates based on the most current census, creates challenges among hospitals to attract patients. Furthermore, although the System maintains a diversified investment portfolio, the System's investments are subject to the inherent risk and volatility associated with global financial markets. The System continuously monitors the environment in which it operates and is engaged in various strategic initiatives to address its cost structure and reimbursement challenges to make healthcare affordable to patients.

Sydell & Arnold Family Pavilion
Cleveland, Ohio

PATIENT VOLUMES

The following table summarizes patient volumes for the System on a pro forma basis including Akron General for all periods presented:

Utilization Statistics

	For the quarter ended September 30				For the nine months ended September 30			
	2016	2015	Variance	%	2016	2015	Variance	%
Inpatient admissions[(1)]								
Acute admissions	40,013	41,795	-1,782	-4.3%	121,196	123,133	-1,937	-1.6%
Post-acute admissions	3,100	3,499	-399	-11.4%	9,444	10,708	-1,264	-11.8%
	43,113	45,294	-2,181	-4.8%	130,640	133,841	-3,201	-2.4%
Patient days[(1)]								
Acute patient days	208,863	215,160	-6,297	-2.9%	632,793	641,926	-9,133	-1.4%
Post-acute patient days	26,414	29,263	-2,849	-9.7%	79,196	89,409	-10,213	-11.4%
	235,277	244,423	-9,146	-3.7%	711,989	731,335	-19,346	-2.6%
Surgical cases								
Inpatient	14,907	15,175	-268	-1.8%	44,974	45,620	-646	-1.4%
Outpatient	37,097	36,766	331	0.9%	110,865	109,098	1,767	1.6%
	52,004	51,941	63	0.1%	155,839	154,718	1,121	0.7%
Emergency department visits	166,910	166,499	411	0.2%	491,665	478,047	13,618	2.8%
Observations	15,233	13,711	1,522	11.1%	43,318	42,519	799	1.9%
Outpatient evaluation and management visits	1,039,611	934,210	105,401	11.3%	3,128,751	2,782,493	346,258	12.4%

[(1)] Excludes newborns

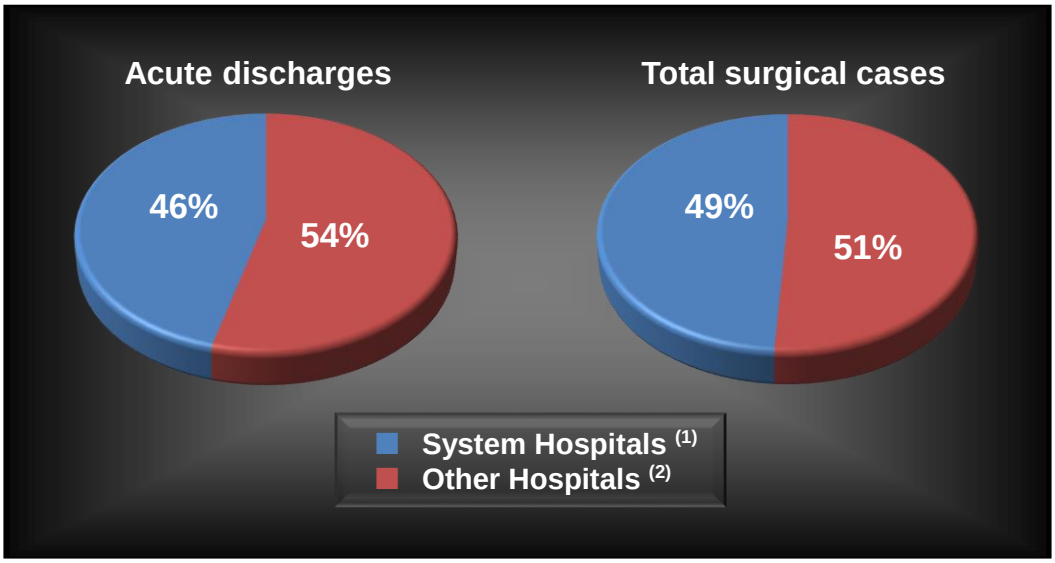
Proforma inpatient acute admissions for the System decreased 4% in the third quarter of 2016 and decreased 2% in the first nine months of 2016 compared to the same periods in 2015. In the first nine months of 2016, the Clinic experienced a 2% decrease in acute admissions and the regional hospitals, which includes Akron General, collectively experienced a 1% decrease in acute admissions. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio service area decreased 2% in the first nine months of 2016 compared to the same period in 2015. The Florida facilities experienced a 1% increase in acute admissions over the same time period.

Proforma post-acute admissions for the System decreased 11% in the third quarter of 2016 and decreased 12.0% in the first nine months of 2016 compared to the same periods in 2015. The decrease was primarily due to the cessation of inpatient services at Lakewood Hospital.

Proforma total surgical cases for the System were flat in the third quarter of 2016 and increased 1% in the first nine months of 2016 compared to the same periods in 2015. For the first nine months of 2016, the increase was driven by a 1% increase at the Clinic's main campus and family health centers and a 5% increase at the Florida facilities. Total surgical cases at the regional hospitals collectively decreased by 1% in the first nine months of 2016 compared to the same period in 2015. According to data from the Center for Health Affairs, total

surgical cases in northeast Ohio increased 3% in the first nine months of 2016 compared to the same period in 2015. The surgical mix of proforma total surgical cases for the System for the first nine months of 2016 was 29% inpatient and 71% outpatient, which represents an approximately 1% shift from inpatient to outpatient compared to the surgical mix in the first nine months of 2015.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the nine months ended September 30, 2016:



Source: The Center for Health Affairs Volume Statistics

(1) "System Hospitals" excludes Florida and Akron General facilities and includes Ashtabula County Medical Center.
(2) "Other Hospitals" includes all other hospitals in northeast Ohio reported by the Center for Health Affairs that are not included in System hospitals.

LIQUIDITY

Cash and Investments

The System's objectives for its investment portfolio are to target returns over the long-term that exceed the System's capital costs so as to optimize its asset/liability mix and preserve and enhance its strong financial structure. The asset allocation of the portfolio is broadly diversified across global equity and global fixed income asset classes and alternative investment strategies and is designed to maximize the probability of achieving the long-term investment objectives at an appropriate level of risk while maintaining a level of liquidity to meet the needs of ongoing portfolio management. This allocation is formalized into a strategic policy benchmark that guides the management of the portfolio and provides a standard to use in evaluating the portfolio's performance.

Investments are primarily maintained in a master trust fund administered using a bank as trustee. The management of the majority of the System's investments is conducted by numerous external investment management organizations that are monitored by management and an external third-party advisor. The System has established formal investment policies that support the System's investment objectives and provides an appropriate balance between return and risk.

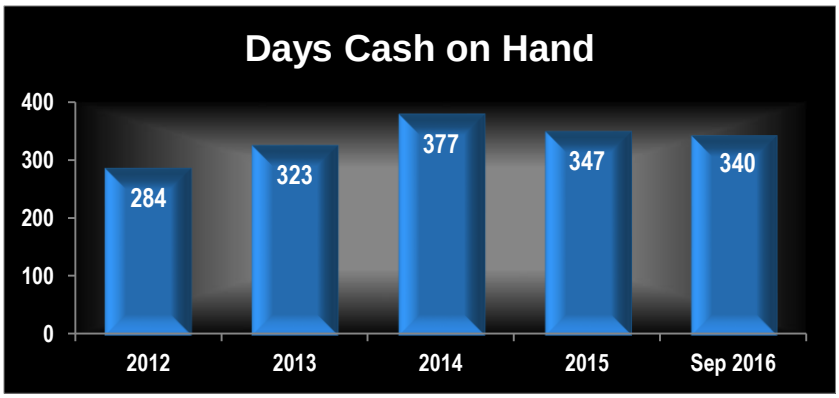
The following table sets forth the allocation of the System's cash and investments at September 30, 2016 and December 31, 2015:

Cash and Investments
(Dollars in thousands)

	September 30, 2016		December 31, 2015	
Cash and cash equivalents	$ 752,956	9%	$ 562,406	8%
Fixed income securities*	1,973,385	26%	1,909,853	26%
Marketable equity securities*	2,740,166	36%	2,503,913	34%
Alternative investments	2,245,469	29%	2,296,184	32%
Total cash and investments	$ 7,711,976	100%	$ 7,272,356	100%
Less restricted investments**	(922,853)		(838,398)	
Unrestricted cash and investments	$ 6,789,123		$ 6,433,958	
Days cash on hand	340		347	

* Fixed income securities and marketable equity securities include mutual funds and commingled investment funds within each investment allocation category.
** Restricted investments include funds held by trustees, assets held for self-insurance and donor restricted assets.

The following chart summarizes days cash on hand for the System at December 31 for the last four years and at September 30, 2016:



At September 30, 2016, total cash and investments for the System (including restricted investments) were $7.712 billion, an increase of $440 million from $7.272 billion at December 31, 2015. Cash inflows consist of cash provided by operating activities and related investment income of $548 million, a net increase in restricted gifts and income of $74 million, and net proceeds from the issuance of short-term and long-term borrowings of $337 million. Cash inflows were offset by net capital expenditures of $426 million and scheduled principal payments on debt of $93 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $169.8 million at September 30, 2016, with an asset mix of 8% cash and short-term investments, 47% fixed-income securities, 31% equity investments and 14% alternative investments. The asset mix reflects the need for liquidity and the objective to maintain stable returns utilizing a lower tolerance for risk and volatility consistent with insurance regulatory requirements.

Also included in the System's cash and investments at September 30, 2016 are $148.4 million of funds held by trustees. Funds held by trustees include $133.7 million of posted collateral related to the System's derivative contracts. The derivative contracts require that collateral be posted when the market value of a contract in a liability position exceeds a certain threshold. The collateral is returned as the liability is reduced. The System also has $11.7 million of funds held by the bond trustee resulting from the issuance of the Series 2014A Taxable Hospital Revenue Commercial Paper Notes (Series 2014A CP Notes). Investment objectives of funds held by the trustees are designed to preserve principal by investing in highly liquid cash or fixed-income investments. At September 30, 2016, the asset mix of funds held by trustees was 27% cash and short-term investments and 73% fixed-income securities.

The System invests in alternative investments to increase the portfolio's diversification. Alternative investments are primarily limited partnerships that invest in marketable securities, privately held securities, real estate, and derivative products and are reported using the equity method of accounting based on information provided by the respective partnership.

Alternative investments at September 30, 2016 and December 31, 2015 consist of the following:

Alternative Investments
(Dollars in thousands)

	September 30, 2016		December 31, 2015	
Hedge funds	$ 1,146,606	51%	$ 1,350,427	59%
Private equity/venture capital	662,453	30%	541,009	24%
Real estate	436,410	19%	404,748	17%
Total alternative investments	$ 2,245,469	100%	$ 2,296,184	100%

Alternative investments have varying degrees of liquidity and are generally less liquid than the traditional equity and fixed income classes of investments. Over time, investors may earn a premium return in exchange for this lack of liquidity. Hedge funds typically contain redeemable interests and offer the most liquidity of the alternative investment classes. These

investment funds permit holders periodic opportunities to redeem interests at frequencies that can range from daily to annually, subject to lock-up provisions that are generally imposed upon initial investment in the fund. It is common, however, that a small portion (5-10%) of withdrawal proceeds are held back from distribution pending the fund's annual audit, which can be up to a year away. Private equity, venture capital, and real estate funds typically have non-redeemable partnership interests. Due to the inherent illiquidity of the underlying investments, the funds generally contain lock-up provisions that prohibit redemptions during the fund's life. Distributions from the funds are received as the underlying investments in the fund are liquidated. These investments have an initial subscription period, under which commitments are made to contribute a specified amount of capital as called for by the general partner of the fund. The System periodically reviews unfunded commitments to ensure adequate liquidity exists to fulfill anticipated contributions to alternative investments.

Investment Return

Return on investments, including equity method income on alternative investments, is reported as nonoperating gains and losses except for earnings on funds held by bond trustees and interest and dividends earned on assets held by the captive insurance subsidiary, which are included in other unrestricted revenues. Donor restricted investment return on temporarily and permanently restricted investments is included in temporarily restricted net assets.

The System's long-term investment portfolio, which excludes assets held for self-insurance, reported investment gains of 3.1% for the third quarter of 2016, which is higher than the portfolio's benchmark gain of 2.7% and higher than investment losses of 4.7% experienced in the third quarter of 2015. For the first nine months of 2016, the System experienced investment gains of 5.4%, which is lower than the portfolio's benchmark gain of 6.5% and higher than the investment losses of 1.9% experienced for the first nine months of 2015.

Medina General Hospital
Medina, Ohio

Total investment return for the System is comprised of the following:

Investment Return
(Dollars in thousands)

	For the quarter ended September 30		For the nine months ended September 30	
	2016	2015	2016	2015
Other unrestricted revenue:				
Interest income and dividends	$ 800	$ 551	$ 2,138	$ 1,733
Nonoperating gains and losses, net:				
Interest income and dividends	15,030	13,475	43,077	36,602
Net realized gains on sales of investments	141,640	42,396	136,138	121,735
Net change in unrealized gains (losses) on investments	31,660	(338,518)	149,992	(325,875)
Equity method income on alternative investments	49,612	9,203	51,185	61,888
Investment management fees	(5,036)	(4,524)	(14,746)	(12,659)
	232,906	(277,968)	365,646	(118,309)
Other changes in net assets:				
Net change in unrealized gains (losses) on nontrading investments	52	(2,557)	(179)	(4,942)
Investment income (loss) on restricted investments	13,920	(16,842)	21,101	(5,507)
Total investment return	$ 247,678	$ (296,816)	$388,706	$ (127,025)

Pension Investments

In 2014, the System updated its investment strategy and modified the allocation of pension plan investments in the CCHS Retirement Plan (Plan), the System's primary defined benefit pension plan. The Plan ceased benefit accruals for substantially all employees as of December 31, 2009, and ceased benefit accruals for remaining employees at various intervals through December 31, 2012. As of December 31, 2015, the Plan had investments of $1.1 billion, which was 87% of the projected benefit obligation. Coincident with the updated investment strategy, the System reduced the asset allocation for common and preferred stocks with a corresponding increase in fixed income securities. The updated investment strategy was implemented because of the funded status of the Plan and the anticipation that such changes in investment strategy will result in lower volatility of future changes in funded status. Once the new investment strategy is fully implemented, it is anticipated that the duration of the investment assets will match the liabilities of the Plan over time. Additional revisions in asset allocations may occur based on future changes in the funded status of the Plan. In September 2016, the System contributed $100 million to the Plan. As of September 30, 2016, the Plan's investments totaled $1.2 billion, which was comprised of 8% cash and cash equivalents, 47% fixed-income investments, 29% equities, and 16% alternative investments.

Long-term Debt

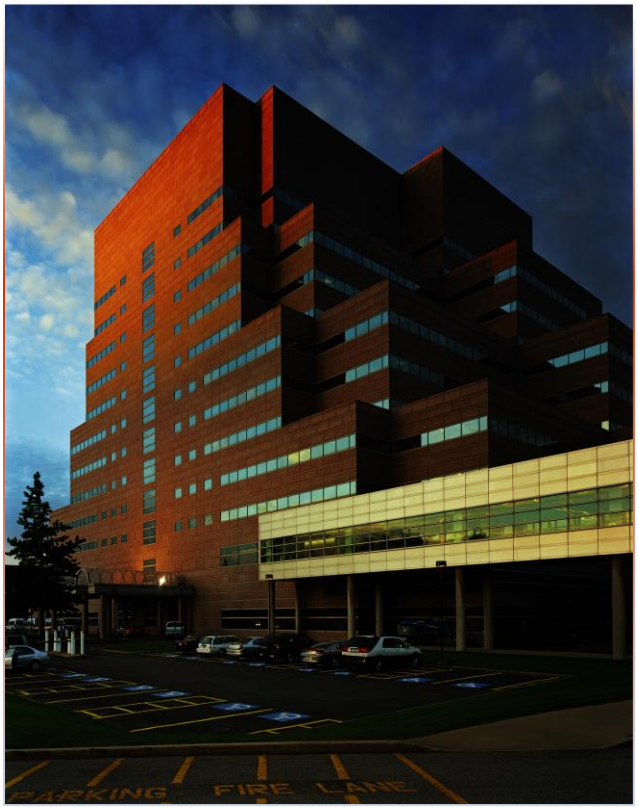
At September 30, 2016, outstanding hospital revenue bonds for the System totaled $3.497 billion, comprised of $2.701 billion (77%) of fixed-rate bonds, $11 million (<1%) of index-rate bonds and $785 million (22%) of variable-rate bonds. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds and certain variable-rate operating lease payments. The total notional amount on the System's interest rate swap contracts at September 30, 2016 was $638 million. Using an interest rate benchmark, these contracts convert variable-rate debt to a fixed-rate, which further reduces the System's exposure to variable interest rates. The interest rate swap contracts can be unwound by the System at any time, whereas the counterparty has the option to unwind the contracts only upon an event of default as defined in the contracts.

Approximately $373 million of the variable-rate bonds are secured by irrevocable direct pay letters of credit or standby bond purchase agreements. Bonds are classified as current liabilities if they are supported by letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year, or contain a subjective clause that, if declared by the lender, could cause immediate repayment of the bonds.

The remaining $412 million variable-rate bonds are supported by the System's self-liquidity program. Bonds supported by self-liquidity include the Series 2014A CP Notes and certain variable-rate bonds that are remarketed in commercial paper mode. Bonds in the self-liquidity program are structured with various term dates so that no more than $50 million of bonds mature within a five-day period. Bonds supported by self-liquidity are classified as current liabilities.

In November 2014, the System established the Cleveland Clinic Health System Obligated Group Commercial Paper Program, which provides for the issuance of the Series 2014A CP Notes. The Series 2014A CP Notes may be issued from time to time in a maximum outstanding face amount of $100 million and will be supported by the System's self-liquidity program. At September 30, 2016 the System has $100 million in outstanding Series 2014A CP Notes.

Combined current aggregate scheduled principal payments by calendar year, assuming the remarketing of the variable-rate bonds for the five years subsequent to December 31, 2015, are as follows (in millions): 2016 – $60.8; 2017 – $65.6; 2018 – $68.0; 2019 – $71.4; and 2020 – $73.9. The System has paid $60.7 million of regularly scheduled principal payments in the first nine months of 2016.



Crile Building
Cleveland, Ohio

Outstanding hospital revenue bonds for the System as of September 30, 2016 and December 31, 2015 consist of the following:

Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	September 30 2016	December 31 2015
2016	CCHS Obligated Group	Fixed	2046	$ 325,000	$ -
2014	CCHS Obligated Group	Fixed	2114	400,000	400,000
2014A	CCHS Obligated Group	CP Notes	2044	100,000	-
2014A	Akron General	Variable	2031	-	70,925
2014B	Akron General	Variable	2031	-	20,000
2013A	CCHS Obligated Group	Fixed / Index	2042	73,150	81,225
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	65,030	65,030
2012A	CCHS Obligated Group	Fixed	2039	460,080	469,485
2012TEFR	Akron General	Fixed	2031	-	39,835
2012TVR	Akron General	Variable	2031	-	17,370
2011A	CCHS Obligated Group	Fixed	2032	172,030	181,180
2011B	CCHS Obligated Group	Fixed	2031	29,120	31,250
2011C	CCHS Obligated Group	Fixed	2032	170,995	170,995
2009A	CCHS Obligated Group	Fixed	2039	305,400	305,400
2009B	CCHS Obligated Group	Fixed	2039	366,215	380,455
2008A	CCHS Obligated Group	Fixed	2043	409,740	419,690
2008B	CCHS Obligated Group	Variable	2043	369,250	369,250
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
2002	CCHS Obligated Group	Variable	2032	9,790	9,940
				$ 3,498,865	$ 3,275,095

In October 2015, the System through a subsidiary entered into a term loan agreement with a financial institution for a principal amount of $375 million. The proceeds of the term loan were used to finance the System's international business strategy. The term loan matures in 2018 and bears interest at a variable-rate based on the LIBOR index plus an applicable spread. The Clinic provides a guarantee on the term loan.

In January 2016, the System entered into a line of credit with a financial institution totaling $60.0 million. The System drew the full amount on the line of credit and also issued $100.0 million of Series 2014A CP Notes. A portion of the proceeds from the draw on the line of credit and the issuance of the Series 2014A CP Notes were used to defease the Series 2012 Akron Bonds and redeem the Series 2012 taxable Akron Bonds, the Series 2014A Akron Bonds and the Series 2014B Akron Bonds.

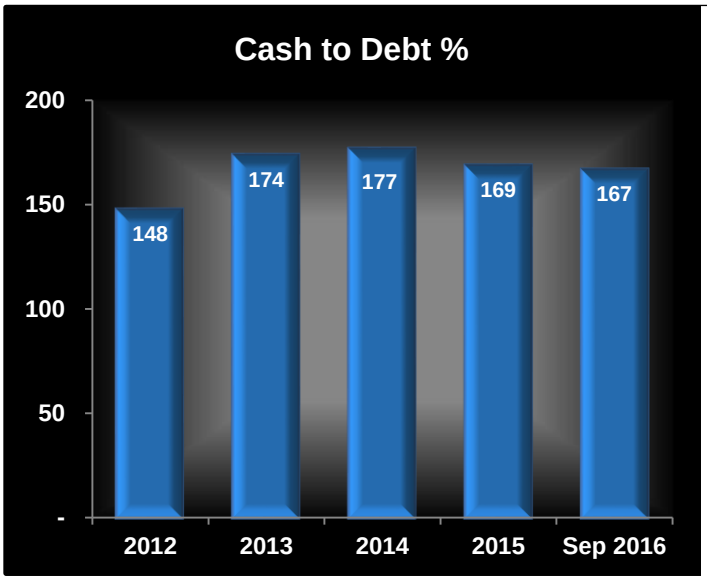
In August 2016, the Foundation issued private placement notes (Notes) totaling $325.0 million that were purchased by a financial institution. The Notes mature in 2046 and bear interest at a

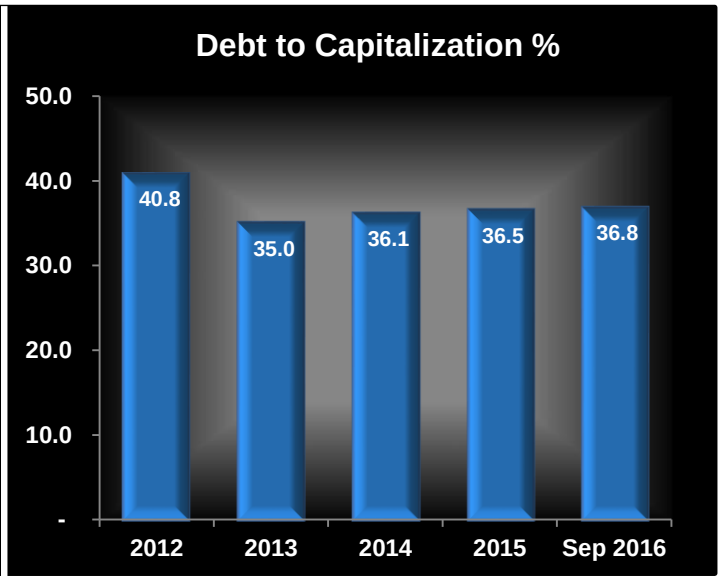
fixed rate of 3.35%. The proceeds of the Notes will be used for the general corporate purposes of the Foundation.

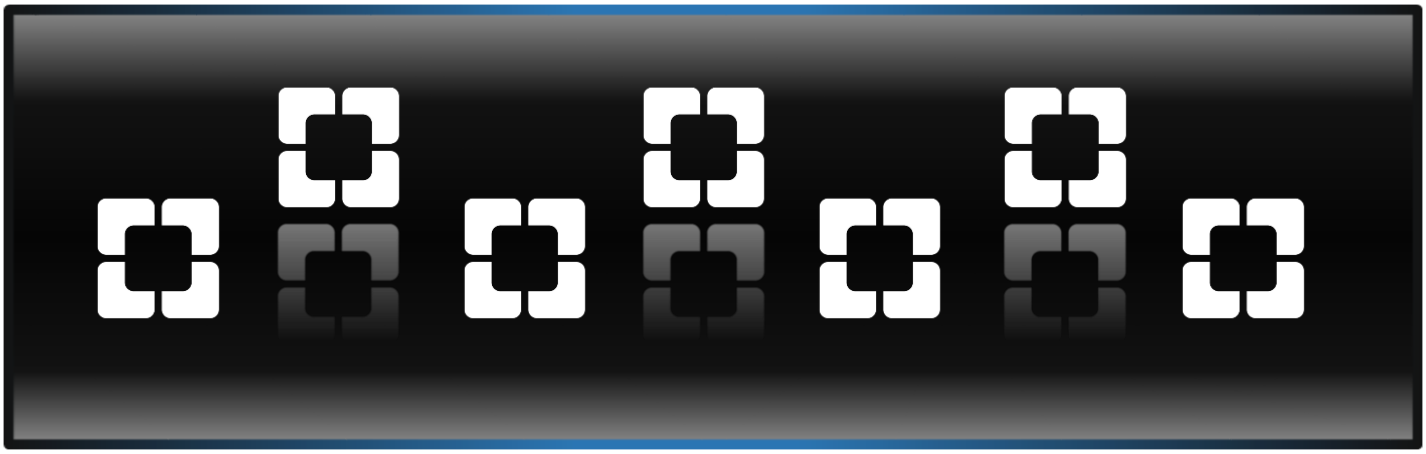
In September 2016, the Clinic entered into a $300.0 million revolving credit facility with multiple financial institutions. The revolving credit facility expires in 2019 with provisions allowing the Clinic to extend the term for one-year periods. The revolving credit facility bears interest at a variable rate based on the LIBOR index plus an applicable spread. Amounts outstanding on the revolving credit facility as of September 30, 2016 totaled $60.0 million. The proceeds were used to pay the full outstanding amount on the line of credit that was executed in January 2016.

In November 2016, the System entered into a loan agreement with a financial institution totaling $17.4 million. The loan matures in 2026 and bears interest at a variable rate based on the London Interbank Offered Rate (LIBOR) plus an applicable spread. The proceeds of the loan were used to pay a portion of the outstanding Series 2014A CP Notes.

The following charts summarize cash-to-debt and debt-to-capitalization ratios for the System at December 31 for the last four years and at September 30, 2016:







BOND RATINGS

The obligated group's outstanding bonds have been assigned ratings of Aa2 (stable outlook) and AA- (positive outlook) by Moody's and S&P, respectively. In February 2016, Moody's and S&P affirmed their respective rating and outlook.

The following table lists the various bond rating categories for Moody's and S&P:

Bond Ratings

	Rating category		
	Moody's	S&P	Definition
Stongest	Aaa	AAA	Prime
↑	Aa	AA	High grade/high quality
↕	A	A	Upper medium grade
↕	Baa	BBB	Lower medium grade
↕	Ba	BB	Non-investment grade/speculative
↕	B	B	Highly speculative
↓	Caa/Ca	CCC	Extremely speculative
Weakest	C	D	Default or bankruptcy
Cleveland Clinic	Aa2	AA-	

Within each rating category are the following modifiers:
Moody's ratings: 1 indicates higher end, 2 indicates mid-range, 3 indicates lower end
S&P ratings: + indicates higher end, - indicates lower end

Healthcare organizations generally do not achieve a rating of Aaa or AAA from Moody's or S&P, respectively, due to the nature of the healthcare industry. Based on recent ratings summary reports obtained from Moody's and S&P, no healthcare organizations were rated in the prime category.

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended September 30, 2016 and 2015

The following narrative describes the consolidated results of operations for the System for the quarters ended September 30, 2016 and 2015. The consolidated results of operations for the quarter ended September 30, 2016 includes the financial operations of Akron General and Grosvenor Place, both of which became consolidated entities of the System in the fourth quarter of 2015. For comparative purposes, certain financial activity in the narrative below is also presented on a same facility basis, which excludes the financial operations of Akron General and Grosvenor Place for the quarter ended September 30, 2016.

Operating income for the System in the third quarter of 2016 was $58.4 million, resulting in an operating margin of 2.9%, as compared to

operating income of $128.0 million and an operating margin of 7.2% in the third quarter of 2015. On a same facility basis (excluding Akron General operating income of $1.6 million and Grosvenor Place operating loss of $5.1 million), operating income for the System for the third quarter of 2016 was $61.9 million, resulting in an operating margin of 3.4%. The lower operating income on a same facility basis for the third quarter of 2016 primarily resulted from a 6.8% increase in total operating expenses, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs, and purchased services and other fees. The System also recorded $3.7 million in special charges in the third quarter of 2016 related to non-recurring expenses for Grosvenor Place and the transition of healthcare services in the City of Lakewood. Same facility unrestricted revenues increased 2.6% primarily due to increased outpatient volumes and a strong case mix despite lower inpatient activity. Nonoperating gains for the System were $229.2 million in the third quarter of 2016 compared to nonoperating losses of $307.2 million in the third quarter of 2015. The increase from the prior year was primarily a result of gains and losses on investments attributable to overall changes in the financial markets and a favorable variance in derivative gains and losses. Overall, the System reported an excess of revenues over expenses of $287.6 million in the third quarter of 2016, or $286.5 million on a same facility basis, compared to a deficiency of revenues over expenses of $179.2 million in the third quarter of 2015.

The System's net patient service revenue increased $211.0 million (12.6%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, net patient service revenue increased $21.9 million (1.3%). The System experienced same facility decreases in inpatient acute admissions of 5.9% and inpatient surgical cases of 3.7% in the third quarter of 2016 compared to the third quarter of 2015. Same facility outpatient volumes increased in the third quarter of 2016 compared to the third quarter of 2015 as outpatient evaluation and management visits increased 11.3%, emergency department visits increased 0.6% and outpatient surgical cases increased 1.2%. The System has also experienced an increase in Medicare and Medicaid revenue primarily as a result of the Affordable Care Act and other industry trends. The State of Ohio expanded Medicaid eligibility in 2014, which has increased enrollment in the Medicaid program and allowed former uninsured patients to shift into the expanded Medicaid program. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased more than 1% in the third quarter of 2016 compared to the same period in 2015. The System has experienced a corresponding decrease in managed care and commercial gross revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2016. Net patient revenue has also benefited from the recognition of a $16.4 million shared savings distribution related to the Cleveland Clinic Medicare ACO. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts increased $19.9 million (33.9%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, provision for uncollectible accounts increased $12.9 million (22.0%). The increase is primarily attributable to increases in net patient service revenue and in deductible and copayment balances. The growth in high deductible health plans is an industry trend that will likely continue to accelerate, particularly as patients enroll in a health plan on the newly

formed exchanges offered under the Affordable Care Act. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances continue to grow and are more difficult to collect than traditional insurance payors. Management continues to monitor the changing healthcare environment and resulting impact on the System and is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare affordable to patients.

Other unrestricted revenues increased $43.9 million (27.7%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, other unrestricted revenues increased $37.4 million (23.6%). The increase in same facility revenues was primarily due to a $12.2 million increase in unrestricted gifts and assets released from restrictions, a $10.7 million increase in outpatient pharmacy revenue, a $9.6 increase in international contract management revenue and a $4.5 million increase in revenue related to research and education grants.

Total operating expenses increased $304.6 million (18.5%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, total operating expenses increased $112.5 million (6.8%). Included in this increase are special charges of $1.4 million related to Lakewood Hospital and the transition of healthcare services in the City of Lakewood, Ohio, and a $12.0 million increase in costs related to a specialty pharmacy. In 2015 the System implemented salary adjustments to caregivers in nursing and other clinical institutes, which has increased salaries and wages in 2016. The System has also experienced an increase in purchased service expenses and consulting expenses related to certain strategic projects and initiatives. To address the growth in expenses caused by inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System has implemented Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. The System continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries and benefits increased $179.4 million (19.4%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, salaries and benefits increased $79.7 million (8.6%). Same facility salaries, excluding benefits, increased $78.4 million (9.8%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2016 and a 4.9% increase in average full-time equivalent employees in the third quarter of 2016 compared to the same period in 2015. The System has also invested in its caregivers in 2015 by increasing the minimum wage across the System, increasing the starting salary for nurses and providing salary adjustments to current caregivers in nursing and other clinical institutes. Same facility employee benefit costs increased $1.3 million (1.0%). The System experienced a $10.6 million increase in retirement benefit expenses and a $4.4 million increase in FICA expenses. These increases were offset by a $15.6 million decrease in employee and retiree health care costs.

Supplies expense increased $22.9 million (14.1%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, supplies expense increased $3.9 million (2.4%). The System experienced a $3.9 million increase in same facility implantables and other medical supplies while same facility non-medical supplies were flat in the third quarter of 2016

compared to the third quarter of 2015. To address the challenge of rising supply and service costs in the healthcare industry, management is engaged in an organizational transformation program to identify and implement clinical and non-clinical savings initiatives through renegotiation, product standardization, utilization changes and improvements in procurement to payment processes.

Pharmaceutical costs increased $41.3 million (22.9%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, pharmaceutical costs increased $26.7 million (14.8%). The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $12.0 million in the third quarter of 2016 compared to the same period in 2015. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $29.5 million (29.0%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, purchased services and other fees increased $6.3 million (6.2%). The increase in same facility purchased service expenses was primarily due to a $2.7 million increase in various purchased non-medical service costs related to certain System projects and initiatives, including the EAPM implementation at the Clinic's main campus and family health centers, a $1.8 million increase in software and hardware technology costs and a $1.6 million increase in purchased medical services primarily related to external lab services.

Administrative services decreased $0.7 million (1.4%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, administrative services decreased $5.1 million (10.4%). The decrease in same facility administrative services was primarily due to a $7.8 million administrative service expense recorded in the third quarter of 2015 related to the acquisition of Grosvenor Place. The decrease in administrative services in the third quarter of 2016 compared to the third quarter of 2015 was offset by an increase in other consulting fees and professional services of $2.1 million related to certain strategic initiatives of the System, an increase in travel and professional education expenses of $0.5 million and an increase in expenses related to research activities of $0.5 million.

Facilities expense increased $4.3 million (5.6%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, facilities expense decreased $7.1 million (9.2%). The decrease in same facility facilities expense was primarily due to a $3.2 million decrease in repairs and maintenance costs across the System, a $1.8 million decrease in utilities and other building service costs and a $0.8 million decrease in operating lease costs.

Insurance expense increased $1.1 million (7.7%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, insurance expense decreased $1.1 million (7.7%). The decrease in same facility insurance expense was primarily due to a decrease in professional malpractice expense. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk

management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense increased $3.8 million (12.2%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, interest expense increased $2.0 million (6.4%). The System issued $325.0 million of fixed-rate private placement notes in the third quarter of 2016. In addition, the System issued $100.0 million of the Series 2014A CP Notes and a $60 million line of credit in January 2016. These increases in debt were offset by $93.4 million of principal payments on bonds, notes and capital leases in 2016 and the defeasance and redemption of bonds related to Akron General, which reduced the amount of interest due on outstanding debt.

Depreciation and amortization expenses increased $19.4 million (19.2%) in the third quarter of 2016 compared to the same period in 2015. On a same facility basis, depreciation and amortization expenses increased $6.0 million (5.9%). Changes in depreciation include property, plant and equipment that was fully depreciated in 2015, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2016.

The System incurred and recorded $3.7 million of special charges in the third quarter of 2016. Special charges in the third quarter of 2016 are comprised of $2.3 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place and $1.4 million related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a detailed description of the terms of the agreement, refer to "LAKEWOOD HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $229.2 million in the third quarter of 2016 compared to a net loss of $307.2 million in 2015. Investment returns were favorable by $510.9 million in the third quarter of 2016 compared to the same period in 2015. The System's long-term investment portfolio reported investment gains of 3.1% for the third quarter of 2016, which is higher than the portfolio's benchmark gain of 2.7% and higher than investment losses of 4.7% experienced in the third quarter of 2015. Derivative losses were favorable by $26.0 million in the third quarter of 2016 compared to the same period in 2015. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements.

For the Nine Months Ended September 30, 2016 and 2015

The following narrative describes the consolidated results of operations for the System for the nine months ended September 30, 2016 and 2015. The consolidated results of operations for the nine months ended September 30, 2016 includes the financial operations of Akron General and Grosvenor Place, both of which became consolidated entities of the System in

the fourth quarter of 2015. For comparative purposes, certain financial activity in the narrative below is also presented on a same facility basis, which excludes the financial operations of Akron General and Grosvenor Place for the nine months ended September 30, 2016.

Operating income for the System in the first nine months of 2016 was $106.1 million, resulting in an operating margin of 1.8%, as compared to operating income of $316.4 million and an operating margin of 6.2% in the first nine months of 2015. On a same facility basis (excluding Akron General operating income of $0.1 million and Grosvenor Place operating loss of $11.1 million), operating income for the System for the first nine months of 2016 was $117.1 million, resulting in an operating margin of 2.2%. The lower operating income on a same facility basis for the first nine months of 2016 primarily resulted from a 9.3% increase in total operating expenses, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs and purchased services and other fees. The System also recorded $22.9 million in special charges in the first nine months of 2016 related to non-recurring expenses for Grosvenor Place and the transition of healthcare services in the City of Lakewood. Same facility unrestricted revenues increased 4.8% primarily due to increased outpatient volumes and a strong case mix despite lower inpatient activity. Nonoperating gains for the System were $291.3 million in the first nine months of 2016 compared to nonoperating losses of $147.9 million in the first nine months of 2015. The increase from the prior year was primarily a result of gains and losses on investments attributable to overall changes in the financial markets offset by an unfavorable variance in derivative gains and losses. Overall, the System reported an excess of revenues over expenses of $397.4 million in the first nine months of 2016, or $402.3 million on a same facility basis, compared to an excess of revenues over expenses of $168.5 million in the first nine months of 2015.

The System's net patient service revenue increased $740.5 million (15.3%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, net patient service revenue increased $185.8 million (3.8%). The System experienced same facility decreases in inpatient acute admissions of 2.8% and inpatient surgical cases of 2.4% in the first nine months of 2016 compared to the same period in 2015. Same facility outpatient volumes increased in the first nine months of 2016 compared to the same period in 2015 as outpatient evaluation and management visits increased 12.4%, emergency department visits increased 3.3% and outpatient surgical cases increased 1.8%. The System has also experienced an increase in Medicare and Medicaid revenue primarily as a result of the Affordable Care Act and other industry trends. The State of Ohio expanded Medicaid eligibility in 2014, which has increased enrollment in the Medicaid program and allowed former uninsured patients to shift into the expanded Medicaid program. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased more than 1% in the third quarter of 2016 compared to the same period in 2015. The System has experienced a corresponding decrease in managed care and commercial gross revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2016. Net patient revenue has also benefited from the recognition of a $16.4 million shared savings distribution related to the Cleveland Clinic Medicare ACO. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts decreased $44.9 million (22.9%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, provision for uncollectible accounts decreased $20.5 million (10.5%). The decrease is primarily attributable to increases in net patient service revenue and in deductible and copayment balances. The growth in high deductible health plans is an industry trend that will likely continue to accelerate, particularly as patients enroll in a health plan on the newly formed exchanges offered under the Affordable Care Act. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances continue to grow and are more difficult to collect than traditional insurance payors. Management continues to monitor the changing healthcare environment and resulting impact on the System and is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare affordable to patients.

Other unrestricted revenues increased $106.2 million (22.4%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, other unrestricted revenues increased $82.1 million (17.4%). The increase in same facility revenues was primarily due to a $43.3 million increase in outpatient pharmacy revenue, a $33.2 increase in international contract management revenue, a $13.6 million increase in revenue related to research and education grants and a $10.5 million increase in unrestricted gifts and assets released from restriction. These increases were offset by $10.9 million of revenue recorded in 2015 related to the sale of a Cleveland Clinic Innovations spin-off company and $3.3 million of equity earnings related to the System's investment in Akron General prior to the member substitution.

Total operating expenses increased $1.0 billion (21.0%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, total operating expenses increased $446.8 million (9.3%). Included in this increase are special charges of $15.2 million related to Lakewood Hospital and the transition of healthcare services in the City of Lakewood, Ohio, and a $47.7 million increase in costs related to a specialty pharmacy. In 2015 the System implemented salary adjustments to caregivers in nursing and other clinical institutes, which has increased salaries and wages in 2016. The System has also experienced an increase in purchased service expenses and consulting expenses related to certain strategic projects and initiatives. To address the growth in expenses caused by inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System has implemented Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. The System continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries and benefits increased $558.0 million (20.1%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, salaries and benefits increased $258.9 million (9.3%). Same facility salaries, excluding benefits, increased $237.7 million (10.1%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2016 and a 4.5% increase in average full-time equivalent employees in the first nine months of 2016 compared to the same period in 2015. The System has also invested in its caregivers in 2015 by increasing the minimum wage across the System, increasing the starting salary for

nurses and providing salary adjustments to current caregivers in nursing and other clinical institutes. Same facility employee benefit costs increased $21.2 million (5.1%). The System experienced a $28.6 million increase in retirement benefit expenses and a $14.4 million increase in FICA expenses. These increases were offset by a $21.7 million decrease in employee and retiree health care costs.

Supplies expense increased $72.5 million (15.0%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, supplies expense increased $18.7 million (3.9%). The System experienced an $18.5 million increase in same facility implantables and other medical supplies and a $0.2 million increase in same facility non-medical supplies. To address the challenge of rising supply and service costs in the healthcare industry, management is engaged in an organizational transformation program to identify and implement clinical and non-clinical savings initiatives through renegotiation, product standardization, utilization changes and improvements in procurement to payment processes.

Pharmaceutical costs increased $139.6 million (28.1%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, pharmaceutical costs increased $98.5 million (19.8%). The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $47.7 million in the first nine months of 2016 compared to the same period in 2015. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $92.4 million (32.6%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, purchased services and other fees increased $30.5 million (10.8%). The increase in same facility purchased service expenses was primarily due to a $15.5 million increase in various purchased non-medical service costs related to certain System projects and initiatives, including the EAPM implementation at the Clinic's main campus and family health centers and new technology for the Human Resources Department, a $4.4 million increase in software and hardware technology costs and a $4.0 million increase in purchased medical services primarily related to external lab services.

Administrative services increased $24.1 million (20.7%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, administrative services increased $11.4 million (9.8%). The increase in same facility administrative services was primarily due to an increase in consulting fees and other professional services of $6.3 million related to certain strategic initiatives of the System, an increase in travel and professional education expenses of $4.1 million and an increase in expenses related to research activities of $1.5 million.

Facilities expense increased $39.9 million (18.5%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, facilities expense increased $2.9 million (1.3%). The increase in same facility facilities expense was primarily due to an increase in repairs and maintenance costs across the System.

Insurance expense increased $6.4 million (12.9%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, insurance expense decreased $0.2 million (0.5%). The decrease in same facility

insurance expense was primarily due to an decrease in professional malpractice expense. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense increased $7.1 million (7.7%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, interest expense increased $1.5 million (1.6%). The System issued $325.0 million of fixed-rate private placement notes in the third quarter of 2016. In addition, the System issued $100.0 million of the Series 2014A CP Notes and a $60 million line of credit in January 2016. These increases in debt were offset by $93.4 million of principal payments on bonds, notes and capital leases in 2016 and the defeasance and redemption at bonds related to Akron General, which reduced the amount of interest due on outstanding debt.

Depreciation and amortization expenses increased $49.2 million (16.2%) in the first nine months of 2016 compared to the same period in 2015. On a same facility basis, depreciation and amortization expenses increased $9.4 million (3.1%). Changes in depreciation include property, plant and equipment that was fully depreciated in 2015, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2016.

The System incurred and recorded $22.9 million of special charges in the first nine months of 2016. Special charges in the first nine months of 2016 are comprised of $7.7 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place and $15.2 million related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a detailed description of the terms of the agreement, refer to "LAKEWOOD HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $291.3 million in the first nine months of 2016 compared to a net loss of $147.9 million in 2015. Investment returns were favorable by $484.0 million in the first nine months of 2016 compared to the same period in 2015. The System's long-term investment portfolio reported investment gains of 5.4% for the first nine months of 2016, which is lower than the portfolio's benchmark gain of 6.5% and higher than investment losses of 1.9% experienced in the first nine months of 2015. Derivative losses were unfavorable by $38.7 million in the first nine months of 2016 compared to the same period in 2015. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's

foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements.

BALANCE SHEET – SEPTEMBER 30, 2016 COMPARED TO DECEMBER 31, 2015

Patient accounts receivable, net of allowances for uncollectible accounts, increased $107.8 million (11.3%) from December 31, 2015 to September 30, 2016. The increase in patient receivables is partially due to the increase in net patient service revenue resulting from rate increases on the System's managed care contracts that became effective in January 2016. Additionally, the System has experienced a growth in patient responsibility accounts receivable. Patient responsibility accounts, which represents the portion of services that is not paid by a patient's insurance company, have increased as a result of employers shifting a greater portion of the cost of care to employees, typically in the form of co-pays and deductibles. These balances have continued to grow and are generally more difficult to collect than traditional insurance payors. The System records estimated allowances that result in patient accounts receivable being reported at the net amount expected to be received. Days revenue outstanding for the System increased from 47 days at December 31, 2015 to 54 days at September 30, 2016.

Investments for current use, which is comprised of bond trustee funds and assets held for self-insurance, decreased $1.6 million (3.0%) from December 31, 2015 to September 30, 2016. Current bond trustee funds decreased $1.6 million due to the timing of principal and interest payments paid in early 2016 related to certain Akron General bonds that were funded to the bond trustee in December 2015. Assets held for self-insurance reported in investments for current use represents investments that will be used to pay the current portion of estimated claim liabilities. There was no change in these investments in the first nine months of 2016.

Other current assets decreased $28.5 million (7.0%) from December 31, 2015 to September 30, 2016. The decrease in other current assets was primarily due to a $26.9 million decrease in receivables related to the timing of receipts for various Medicare and Medicaid programs, a $8.0 million decrease in electronic health record incentive program receivables due to the timing of payments for this program, collection of a $7.3 million miscellaneous receivable that was accrued in 2015 and a $6.8 million decrease in the current portion of pledges receivable. These decreases were offset by an $8.3 million increase in prepaid expenses primarily related to annual maintenance contracts, an $8.8 million increase in international management contract receivables and a $7.5 million increase in inventories.

Unrestricted long-term investments increased $188.9 million (3.1%) from December 31, 2015 to September 30, 2016. Total unrestricted cash, cash equivalents and long-term investments increased $355.2 million from December 31, 2015 to September 30, 2016. The System experienced $548.0 million of net positive cash flow from operations and investment income in the first nine months of 2016. The System also issued $325 million of private placement notes in August 2016 and used the proceeds for the general corporate purposes of the System. These increases were primarily offset by net capital expenditures of $426.1 million and

principal payment on long-term debt of $93.4 million.

Funds held by trustees increased $22.7 million (18.1%) from December 31, 2015 to September 30, 2016. The increase in funds held by trustees is primarily due to a $39.6 million increase in collateral posted with the counterparties on the System's derivative contracts and $11.7 million of remaining project funds from the issuance of the Series 2014 CP Notes. These increases were offset by a $24.7 million reduction of collateral that was used to support a futures and options program within the System's investment portfolio and a $4.0 million reduction in a debt service reserve fund related to Akron General bonds. The debt service reserve fund was returned to the System in the first quarter of 2016 when the related Akron bonds were defeased.

Assets held for self-insurance increased $24.0 million (25.6%) from December 31, 2015 to September 30, 2016. The increase in self-insurance assets is primarily due to insurance premiums received by the captive in excess of reimbursement payments for claims previously settled and paid by other System entities and investment gains experienced in the System's captive insurance subsidiary.

Donor restricted assets increased $39.4 million (7.0%) from December 31, 2015 to September 30, 2016. The increase in donor restricted assets was primarily from the receipt of donor restricted gifts in excess of expenditures from restricted funds and investment gains on restricted investments.

Net property, plant and equipment increased $50.5 million (1.2%) from December 31, 2015 to September 30, 2016. The System had net expenditures for property, plant and equipment of $426.1 million, offset by depreciation expense of $363.3 million, which includes $12.1 million of accelerated depreciation expense recorded in special charges. Capital expenditures in 2016 include amounts paid on retainage liabilities recorded at December 31, 2015 and exclude assets acquired through capital lease arrangements. Retainage liabilities decreased $24.4 million and new capital leases totaled $11.1 million in the first nine months of 2016. Expenditures for property, plant and equipment were incurred at numerous facilities across the System and include expenditures for strategic construction, expansion and technological investment as well as replacement of existing facilities and equipment. For a complete description of many of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets increased $33.3 million (5.7%) from December 31, 2015 to September 30, 2016. The increase in noncurrent assets was primarily due to a $21.8 increase in a note receivable related to construction financing of a hotel on the Clinic's main campus, a $5.8 million increase related to an investment in a joint venture with Select Medical to operate various long-term acute care hospitals and a $4.1 million increase in goodwill related to certain physician practice acquisitions.

Accounts payable decreased $37.7 million (9.1%) from December 31, 2015 to September 30, 2016. The decrease in accounts payable was primarily attributable to a $24.4 million decrease in retainage liabilities associated with the System's construction projects and an $11.4 million decrease in outstanding checks. Other changes relate to the timing of payment processing for trade payables.

Compensation and amounts withheld from payroll increased $66.8 million (22.6%) from December 31, 2015 to September 30, 2016. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $144.4 million (150.9%) from December 31, 2015 to September 30, 2016. The increase in the current portion of long-term debt was comprised of a $97.9 million increase in current bond payments and a $46.5 million increase in current notes payable and capital leases. The increase in the current portion of bond payments primarily relates to the issuance of the Series 2014 CP Notes for $100 million. The increase in notes payable and capital leases primarily relates to the $60 million draw on the revolving credit facility offset by payments on notes and leases that matured in 2016. The System also reclassified debt from long-term to current, offset by regularly scheduled principal payments.

Variable rate debt classified as current decreased $63.1 million (12.1%) from December 31, 2015 to September 30, 2016. Long-term debt classified as current consists of variable-rate bonds supported by the System's self-liquidity program and bonds with letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds. The reduction in the variable rate debt classified as current in the first nine months of 2016 is primarily due an $86.0 million decrease related to the redemption of the Series 2014A Akron Bonds and the Series 2014B Akron Bonds. This was offset by a $25.1 million increase in variable rate debt classified as current due to a reclassification of debt from long-term that qualifies to be reported as current.

Other current liabilities decreased $14.1 million (3.0%) from December 31, 2015 to September 30, 2016. The decrease in other current liabilities is primarily due to a $29.1 million decrease in accrued interest payable related to fixed-rate bonds that pay interest semi-annually in January and June of each year and a $19.2 million decrease in state franchise fee liabilities due to the timing of the payments for this program. These decreases were offset by a $11.0 million increase in derivative liabilities associated with the changes in fair value of the System's foreign exchange derivative contracts and a $5.8 million increase in deferred revenue related to international management contracts.

Hospital revenue bonds increased $183.9 million (6.7%) from December 31, 2015 to September 30, 2016. The increase in hospital revenue bonds is primarily due to the issuance of $325.0 million of private placement notes in 2016. This was offset by the reclassification of $56.4 million from long-term to current for bond payments due within one year, the reclassification of $25.1 million from long-term to variable rate debt classified as current and the defeasance and redemption of $56.5 million of Akron General bonds that were classified as long-term at December 31, 2015.

Notes payable and capital leases decreased $7.9 million (1.7%) from December 31, 2015 to September 30, 2016. The decrease is primarily due to the reclassification of regularly scheduled principal payments on notes payable and capital leases to current portion of long-term debt, offset by $11.1 million of new capital leases.

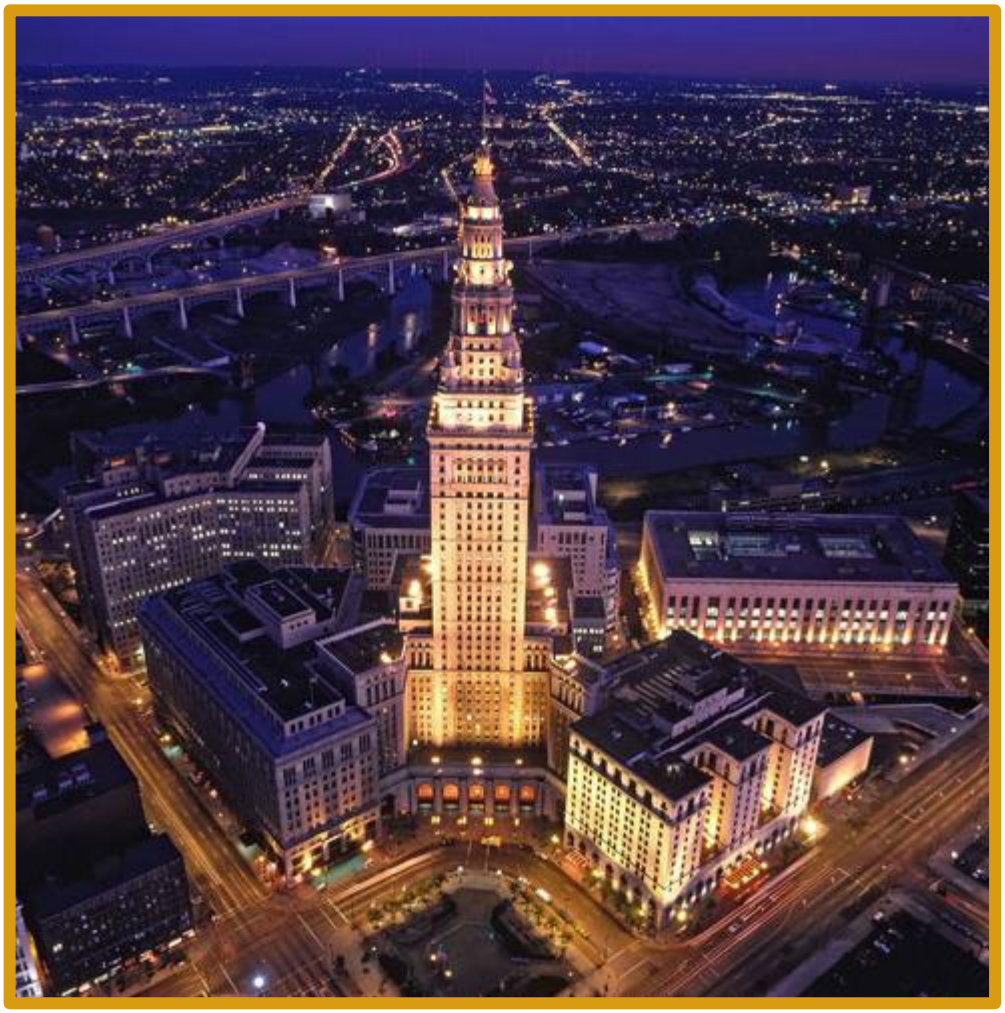
Professional and general insurance liability reserves increased $21.4 million (15.3%) from December 31, 2015 to September 30, 2016. The increase is due to the growth in expected claim liabilities in excess of claim liability payments.

Accrued retirement benefits decreased $122.2 million (24.9%) from December 31, 2015 to September 30, 2016. The System funded $122.0 million to its defined benefit pension plans in the third quarter of 2016.

Other noncurrent liabilities increased $42.1 million (8.8%) from December 31, 2015 to

September 30, 2016. The increase in other noncurrent liabilities is primarily due to a $36.7 million increase in derivative liabilities associated with changes in the fair value of the System's interest rate swap derivative contracts and a $2.3 million increase in long-term self-insured workers compensation liabilities.

Total net assets increased $389.1 million (5.2%) from December 31, 2015 to September 30, 2016. Unrestricted net assets increased $360.4 million (5.4%) primarily due to an excess of revenues over expenses of $397.4 million. Temporarily restricted net assets increased $21.3 million (3.6%), primarily due to $35.6 million in temporarily restricted gifts and $21.1 million in net investment income offset by $36.2 million in assets released from restrictions. Permanently restricted net assets increased $7.4 million (2.5%) primarily due to $12.4 million of permanently restricted gifts offset by a $5.0 million decrease in the value of perpetual trusts.



Cleveland Skyline – Terminal Tower
Cleveland, Ohio

FORWARD-LOOKING STATEMENTS

Forward-looking statements contained in this report and other written reports and oral statements are made based on known events and circumstances at the time of release, and as such, are subject in the future to unforeseen uncertainties and risks. All statements regarding future performance, events or developments are forward-looking statements. It is possible that the System's future performance may differ materially from current expectations depending on economic conditions within the healthcare industry and other factors. Among other factors that might affect future performance are:

- Changes to the Medicare and Medicaid reimbursement systems resulting in reductions in payments, and/or changes in eligibility of patients to qualify for Medicare and Medicaid;
- Legislative reforms or actions that reduce the payment for, and/or utilization of, healthcare services, such as the Patient Protection and Affordable Care Act and/or draft legislation to address reimbursement cuts related to the Sustainable Growth Rate Formulas;
- Possible repeal and/or replacement of the Patient Protection and Affordable Care Act;
- Adjustments resulting from Medicare and Medicaid reimbursement audits, including audits initiated by the Medicare Recovery Audit Contractor program;
- Increased competition in the areas served by the System and limited options to respond to the same in part due to uncertainty in the enforcement of antitrust laws;
- The ability of the System to access capital for the funding of capital projects;
- Availability of malpractice insurance at reasonable rates, if at all;
- The System's ability to recruit and retain professionals;
- General economic and business conditions, internationally, nationally and regionally, including the impact of interest rates, foreign currencies, financial market conditions and volatility and increases in the number of self-pay patients;
- The increasing number and severity of cyber threats and the costs of preventing them and protecting patient and other data;
- The declining population in the Greater Cleveland area;
- Impact of federal laws on tax-exempt organizations and state law relating to exemption from income taxes, sales taxes and real estate taxes;
- Management, utilization and increases in the cost of medical drugs and devices as technological advancement progresses without concurrent increases in federal reimbursement;
- Ability of the System to adjust its cost structure and reduce operating expenses; and
- Changes in accounting standards or practices.

The System undertakes no obligation to update or publicly revise these forward-looking statements to reflect events or circumstances that arise after the date of this report.