Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended March 31, 2017

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	March 31 2017	December 31 2016
Assets		
Current assets:		
Cash and cash equivalents	$ 342,547	$ 520,628
Patient receivables, net	1,076,664	1,059,171
Investments for current use	52,126	52,126
Other current assets	435,354	396,892
Total current assets	1,906,691	2,028,817
Investments:		
Long-term investments	6,748,539	6,476,259
Funds held by trustees	85,535	75,892
Assets held for self-insurance	133,340	128,128
Donor restricted assets	638,307	612,221
	7,605,721	7,292,500
Property, plant, and equipment, net	4,496,900	4,512,078
Other assets:		
Pledges receivable, net	154,103	150,709
Trusts and interests in foundations	67,914	67,219
Other noncurrent assets	410,441	410,007
	632,458	627,935
Total assets	$ 14,641,770	$ 14,461,330

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	March 31 2017	December 31 2016
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 388,934	$ 482,427
Compensation and amounts withheld from payroll	363,144	322,493
Current portion of long-term debt	84,951	81,739
Variable rate debt classified as current	527,030	527,115
Other current liabilities	417,501	462,561
Total current liabilities	1,781,560	1,876,335
Long-term debt:		
Hospital revenue bonds	2,868,063	2,926,949
Notes payable and capital leases	515,190	516,719
	3,383,253	3,443,668
Other liabilities:		
Professional and general insurance liability reserves	145,629	146,109
Accrued retirement benefits	473,631	478,874
Other noncurrent liabilities	486,420	490,545
	1,105,680	1,115,528
Total liabilities	6,270,493	6,435,531
Net assets:		
Unrestricted	7,399,938	7,088,209
Temporarily restricted	656,524	627,426
Permanently restricted	314,815	310,164
Total net assets	8,371,277	8,025,799
Total liabilities and net assets	$ 14,641,770	$ 14,461,330

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended March 31	
	2017	2016
Unrestricted revenues		
Net patient service revenue	$ 1,958,379	$ 1,861,080
Provision for uncollectible accounts	(89,096)	(86,419)
Net patient service revenue less provision for uncollectible accounts	1,869,283	1,774,661
Other	199,620	170,276
Total unrestricted revenues	2,068,903	1,944,937
Expenses		
Salaries, wages, and benefits	1,157,237	1,118,988
Supplies	193,625	180,008
Pharmaceuticals	223,665	204,218
Purchased services and other fees	126,126	120,339
Administrative services	44,051	45,195
Facilities	83,377	87,996
Insurance	20,149	19,877
	1,848,230	1,776,621
Operating income before interest, depreciation, and amortization expenses	220,673	168,316
Interest	36,173	32,457
Depreciation and amortization	121,829	115,769
Operating income before special charges	62,671	20,090
Special charges	1,958	12,727
Operating income	60,713	7,363
Nonoperating gains and losses		
Investment return	242,682	13,471
Derivative gains (losses)	2,056	(34,343)
Other, net	3,111	(3,667)
Net nonoperating gains and losses	247,849	(24,539)
Excess (deficiency) of revenues over expenses	308,562	(17,176)

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
Balances at January 1, 2016	$ 6,627,406	$ 586,276	$ 295,316	$ 7,508,998
Deficiency of revenues over expenses	(17,176)	-	-	(17,176)
Donated capital and assets released from restrictions for capital purposes	1,154	(1,154)	-	-
Gifts and bequests	-	11,935	3,046	14,981
Transfer of net assets	1,910	(1,910)	-	-
Net investment income	-	4,780	-	4,780
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(7,588)	-	(7,588)
Retirement benefits adjustment	(555)	-	-	(555)
Change in interests in foundations	-	(2)	-	(2)
Change in value of perpetual trusts	-	-	(1,540)	(1,540)
Net change in unrealized losses on nontrading investments	(666)	-	-	(666)
Other	(8,643)	-	-	(8,643)
(Decrease) increase in net assets	(23,976)	6,061	1,506	(16,409)
Balances at March 31, 2016	$ 6,603,430	$ 592,337	$ 296,822	$ 7,492,589
Balances at January 1, 2017	$ 7,088,209	$ 627,426	$ 310,164	$ 8,025,799
Excess of revenues over expenses	308,562	-	-	308,562
Donated capital and assets released from restrictions for capital purposes	907	(907)	-	-
Gifts and bequests	-	23,497	4,106	27,603
Net investment income	-	14,402	-	14,402
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(7,894)	-	(7,894)
Retirement benefits adjustment	(658)	-	-	(658)
Change in value of perpetual trusts	-	-	545	545
Foreign currency translation	3,673	-	-	3,673
Net change in unrealized losses on nontrading investments	(833)	-	-	(833)
Other	78	-	-	78
Increase in net assets	311,729	29,098	4,651	345,478
Balances at March 31, 2017	$ 7,399,938	$ 656,524	$ 314,815	$ 8,371,277

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31	
	2017	2016
Operating activities and net nonoperating gains and losses		
Increase (decrease) in net assets	$ 345,478	$ (16,409)
Adjustments to reconcile increase (decrease) 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	658	555
Net realized and unrealized gains on investments	(248,797)	(9,430)
Depreciation and amortization	121,829	126,806
Provision for uncollectible accounts	89,096	86,419
Foreign currency translation gain	(3,673)	-
Restricted gifts, bequests, investment income, and other	(42,550)	(18,219)
Accreted interest and amortization of bond premiums	(377)	(509)
Net (gain) loss in value of derivatives	(11,813)	28,118
Changes in operating assets and liabilities:		
Patient receivables	(106,589)	(166,673)
Other current assets	(35,655)	(7,239)
Other noncurrent assets	(915)	(17,938)
Accounts payable and other current liabilities	(72,094)	3,043
Other liabilities	(3,679)	13,219
Net cash provided by operating activities and net nonoperating gains and losses	30,919	25,668
Financing activities		
Proceeds from short-term borrowings, net	-	60,000
Proceeds from long-term borrowings	-	100,000
Payments for redemption of long-term debt	-	(148,260)
Principal payments on long-term debt	(61,390)	(66,343)
Debt issuance costs	-	(137)
Change in pledges receivables, trusts and interests in foundations	(6,896)	2,676
Restricted gifts, bequests, investment income, and other	42,550	18,219
Net cash used in financing activities	(25,736)	(33,845)
Investing activities		
Expenditures for property and equipment, net	(119,124)	(137,248)
Net change in cash equivalents reported in long-term investments	(35,178)	108,691
Purchases of investments	(439,490)	(488,953)
Sales of investments	410,244	434,205
Net cash used in investing activities	(183,548)	(83,305)
Effect of exchange rate changes on cash	284	-
Decrease in cash and cash equivalents	(178,081)	(91,482)
Cash and cash equivalents at beginning of year	520,628	249,580
Cash and cash equivalents at end of period	$ 342,547	$ 158,098

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 months ended March 31, 2017 are not necessarily indicative of the results to be expected for the year ending December 31, 2017. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2016.

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 14 hospitals with approximately 3,900 staffed beds. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by the Foundation. The System operates 21 outpatient Family Health Centers, 10 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.

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 in ASU 2014-09, including subsequent amendments, 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 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 Statements for Not-for-Profit Entities*. This standard intends to make certain improvements to the current reporting requirements for not-for-profit entities. This standard sets forth changes to net asset classification requirements and the information presented about a not-for-profit entity's liquidity, financial performance and cash flows. ASU 2016-14 is effective for the System for reporting periods beginning after December 15, 2017. The System is currently evaluating the impact that ASU 2016-14 will have on its financial statements and will adopt the provisions upon the effective date.

3. Accounting Policies (continued)

In March 2017, the FASB issued ASU 2017-07, *Compensation — Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. This ASU requires the service cost component of net periodic benefit cost related to defined benefit pension and postretirement benefit plans to be reported in the same financial statement line as other compensation costs arising from services rendered during the period. The other components of net periodic benefit cost are required to be presented separately from service costs and outside of operating income in the statement of operations. Only the service cost component of net periodic benefit cost will be eligible for capitalization in assets. ASU 2017-07 is effective for the System for annual reporting periods beginning after December 15, 2018 and interim periods within annual reporting periods beginning after December 15, 2019 with early adoption permitted in the first quarter of 2017. Upon adoption, the System is required to apply the new guidance retrospectively to all periods presented in the consolidated financial statements, except for the guidance limiting the capitalization of net periodic benefit costs in assets which is required to be applied prospectively. The System adopted the provisions of ASU 2017-07 in the first quarter of 2017 and retrospectively applied the guidance to all periods presented in the consolidated financial statements. The impact of adopting ASU 2017-07 for the System when applied retrospectively to the three months ended March 31, 2016 increased salaries, wages and benefits on the consolidated statement of operations as presented herein by $0.1 million, with a corresponding decrease to operating income and increase to net nonoperating gains. The adoption of ASU 2017-07 had no impact on excess of revenues over expenses or net assets.

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 three months ended March 31, 2017 and 2016, are as follows (in thousands):

	2017		**2016**	
Medicare	**$ 664,007**	**34%**	$ 598,049	32%
Medicaid	**160,774**	**8**	141,968	8
Managed care and commercial	**1,100,094**	**56**	1,050,137	56
Self-pay	**33,504**	**2**	70,926	4
	$ 1,958,379	**100%**	$ 1,861,080	100%

5. Net Patient Service Revenue and Patient Receivables (continued)

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 uncollectable 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 decreased $24.4 million in the first three months of 2017 compared to the same period in 2016. 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 valuation 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.

6. Fair Value Measurements (continued)

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 current and noncurrent assets and liabilities have carrying values that approximate fair value.

The following tables present the financial instruments measured at fair value on a recurring basis as of March 31, 2017 and December 31, 2016, based on the valuation hierarchy (in thousands):

March 31, 2017	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	**$ 544,639**	**$ 1**	**$ –**	**$ 544,640**
Fixed income securities:				
U.S. treasuries	**1,116,307**	**–**	**–**	**1,116,307**
U.S. government agencies	**–**	**20,071**	**–**	**20,071**
U.S. corporate	**–**	**164,736**	**–**	**164,736**
U.S. government agencies asset-backed securities	**–**	**25,813**	**–**	**25,813**
Corporate asset-backed securities	**–**	**3,384**	**–**	**3,384**
Foreign	**–**	**49,647**	**–**	**49,647**
Fixed income mutual funds	**224,701**	**–**	**–**	**224,701**
Common and preferred stocks:				
U.S.	**430,220**	**2,276**	**–**	**432,496**
Foreign	**303,718**	**1,103**	**–**	**304,821**
Equity mutual funds	**413,812**	**–**	**–**	**413,812**
Total cash and investments	**3,033,397**	**267,031**	**–**	**3,300,428**
Perpetual and charitable trusts	**–**	**46,046**	**–**	**46,046**
Total assets at fair value	**$ 3,033,397**	**$ 313,077**	**$ –**	**$ 3,346,474**
Liabilities				
Interest rate swaps	**$ –**	**$ 132,595**	**$ –**	**$ 132,595**
Foreign currency forward contracts	**$ –**	**$ 6,760**	**$ –**	**$ 6,760**
Total liabilities at fair value	**$ –**	**$ 139,355**	**$ –**	**$ 139,355**

6. Fair Value Measurements (continued)

December 31, 2016	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 687,410	$ –	$ –	$ 687,410
Fixed income securities:				
U.S. treasuries	963,715	–	–	963,715
U.S. government agencies	–	20,270	–	20,270
U.S. corporate	–	167,025	–	167,025
U.S. government agencies asset-backed securities	–	25,102	–	25,102
Corporate asset-backed securities	–	2,829	–	2,829
Foreign	–	44,759	–	44,759
Fixed income mutual funds	222,670	–	–	222,670
Common and preferred stocks:				
U.S.	420,744	2,203	–	422,947
Foreign	265,689	1,372	–	267,061
Equity mutual funds	381,686	–	–	381,686
Total cash and investments	2,941,914	263,560	–	3,205,474
Perpetual and charitable trusts	–	45,350	–	45,350
Total assets at fair value	$ 2,941,914	$ 308,910	$ –	$ 3,250,824
Liabilities				
Interest rate swaps	$ –	$ 139,422	$ –	$ 139,422
Foreign currency forward contracts	$ –	$ 11,076	$ –	$ 11,076
Total liabilities at fair value	$ –	$ 150,498	$ –	$ 150,498

6. Fair Value Measurements (continued)

Financial instruments at March 31, 2017 and December 31, 2016 are reflected in the consolidated balance sheets as follows (in thousands):

	March 31 2017	December 31 2016
Cash, cash equivalents, and investments measured at fair value	**$ 3,300,428**	$ 3,205,474
Commingled funds measured at net asset value	**2,436,668**	2,376,840
Alternative investments accounted for under the equity method	**2,263,298**	2,282,940
Total cash, cash equivalents, and investments	**$ 8,000,394**	$ 7,865,254
Perpetual and charitable trusts measured at fair value	**$ 46,046**	$ 45,350
Interests in foundations	**21,868**	21,869
Trusts and interests in foundations	**$ 67,914**	$ 67,219

Interest rate swaps and forward currency forward contracts (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 fair value of foreign currency forward contracts is based on the difference between the contracted forward rate and current market foreign currency exchange rates. A credit spread adjustment is included in the valuations to appropriately reflect nonperformance risk. The credit spread adjustment is derived from other comparably rated entities' bonds recently priced in the market.

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.

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 $622.1 million and $633.1 million at March 31, 2017 and December 31, 2016, 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 March 31 2017	Notional Amount at December 31 2016
Fixed	2021	3.21%	68% of LIBOR	**31,725**	33,265
Fixed	2024	3.42%	68% of LIBOR	**27,200**	27,800
Fixed	2027	3.56%	68% of LIBOR	**124,303**	128,333
Fixed	2028	5.12%	100% of LIBOR	**37,730**	38,800
Fixed	2028	3.51%	68% of LIBOR	**29,125**	29,965
Fixed	2030	5.07%	100% of LIBOR	**60,825**	60,825
Fixed	2030	5.06%	100% of LIBOR	**60,800**	60,800
Fixed	2031	3.04%	68% of LIBOR	**49,850**	52,625
Fixed	2032	4.32%	79% of LIBOR	**2,341**	2,361
Fixed	2032	4.33%	70% of LIBOR	**4,683**	4,723
Fixed	2032	3.78%	70% of LIBOR	**2,341**	2,361
Fixed	2036	4.90%	100% of LIBOR	**49,725**	49,725
Fixed	2036	4.90%	100% of LIBOR	**78,350**	78,350
Fixed	2037	4.62%	100% of SIFMA	**63,135**	63,135
				$ 622,133	$ 633,068

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 contracts and currency options to manage its exposure to fluctuations in the USD – British Pound (GBP) exchange rate. Currency forward contracts involve fixing the USD – GBP exchange rate for delivery of a specified amount of foreign currency on a specified date. The currency forward contracts are typically cash settled in USD for their fair value at or close to their settlement date. The System has also used currency option contracts to manage its foreign currency exchange risk.

The System has outstanding foreign currency forward contracts, expiring at various dates through September 2017, with a total notional amount of $50 million and $75 million at March 31, 2017 and December 31, 2016, respectively. The foreign currency contracts 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			
	March 31, 2017		December 31, 2016	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 132,595**	Other noncurrent liabilities	$ 139,422
Foreign currency contracts	Other current liabilities	**$ 6,760**	Other current liabilities	$ 11,076

The following table summarizes the location and amounts of derivative gains (losses) on the System's interest rate swap agreements (in thousands):

	Location of Loss Recognized	Quarter Ended March 31 2017	2016
Derivatives not designated as hedging instruments			
Interest rate swap agreements	Derivative gains (losses)	**$ 1,215**	$ (34,343)
Foreign currency contracts	Derivative gains	**$ 841**	$ -

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 March 31, 2017 and December 31, 2016, the System posted $85.3 million and $75.6 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, the System's primary defined benefit pension 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. The System also has a defined benefit pension plan covering Akron General employees that were hired before 2004 who meet certain eligibility requirements. In 2009, the Akron General defined benefit plan ceased benefit accruals for substantially all nonunion employees, with benefits for union employees ceasing 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 for defined benefit pension plans are as follows (in thousands):

	Quarter Ended March 31	
	2017	**2016**
Amounts related to defined benefit pension plans:		
Service cost	**$ 49**	**$ 545**
Interest cost	**17,836**	**19,019**
Expected return on assets	**(21,167)**	**(19,864)**
Net amortization and deferral	**(420)**	**(420)**
Total defined benefit pension plans	**(3,702)**	**(720)**
Defined contribution plans	**61,279**	**57,970**
	$ 57,577	**$ 57,250**

8. Pensions and Other Postretirement Benefits (continued)

The service cost component of net periodic benefit cost is included in salaries, wages and benefits in the consolidated statement of operations. The components of net periodic benefit cost other than the service cost component are included in other nonoperating gains and losses in the consolidated statements of operations.

As of March 31, 2017, the System has made contributions of $1.7 million to the defined benefit pension plans. The System expects to make additional contributions of $10.2 million to the defined benefit pension plans for the remainder of 2017.

9. Special Charges

The System incurred and recorded special charges of $2.0 million and $12.7 million in the first three months of 2017 and 2016, respectively. Special charges are related to Lakewood Hospital and the agreement between the Foundation, Lakewood Hospital Association (LHA) and the City of Lakewood effective 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 17 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 current emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. 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. Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets.

10. Subsequent Events

The System evaluated events and transactions occurring subsequent to March 31, 2017 through May 12, 2017, the date the consolidated financial statements were issued. During this period, there were no subsequent events requiring recognition in the consolidated financial statements, and there were no nonrecognized subsequent events requiring disclosure.

Unaudited Consolidating Balance Sheets

($ in thousands)

	March 31, 2017				December 31, 2016			
	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	$ 337,395	$ 5,152	$ -	$ 342,547	$ 511,102	$ 9,526	$ -	$ 520,628
Patient receivables, net	975,172	134,924	(33,432)	1,076,664	976,060	109,412	(26,301)	1,059,171
Due from affiliates	23,179	62,657	(85,836)	-	4,091	28	(4,119)	-
Investments for current use	-	52,126	-	52,126	-	52,126	-	52,126
Other current assets	350,195	89,142	(3,983)	435,354	313,911	85,292	(2,311)	396,892
Total current assets	1,685,941	344,001	(123,251)	1,906,691	1,805,164	256,384	(32,731)	2,028,817
Investments:								
Long-term investments	6,349,210	399,329	-	6,748,539	6,090,613	385,646	-	6,476,259
Funds held by trustees	85,535	-	-	85,535	75,892	0	-	75,892
Assets held for self-insurance	-	133,340	-	133,340	-	128,128	-	128,128
Donor restricted assets	597,937	40,370	-	638,307	572,982	39,239	-	612,221
	7,032,682	573,039	-	7,605,721	6,739,487	553,013	-	7,292,500
Property, plant, and equipment, net	3,467,912	1,028,988	-	4,496,900	3,478,405	1,033,673	-	4,512,078
Other assets:								
Pledges receivable, net	153,295	808	-	154,103	149,889	820	-	150,709
Trusts and beneficial interests in foundations	59,625	8,289	-	67,914	59,069	8,150	-	67,219
Other noncurrent assets	515,040	51,231	(155,830)	410,441	514,693	51,138	(155,824)	410,007
	727,960	60,328	(155,830)	632,458	723,651	60,108	(155,824)	627,935
Total assets	$12,914,495	$ 2,006,356	$ (279,081)	$14,641,770	$12,746,707	$ 1,903,178	$ (188,555)	$14,461,330

	March 31, 2017				December 31, 2016			
	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	$ 314,174	$ 75,037	$ (277)	$ 388,934	$ 398,704	$ 86,033	$ (2,310)	$ 482,427
Compensation and amounts withheld from payroll	322,520	40,624	-	363,144	289,650	32,843	-	322,493
Short-term borrowings	-	-	-	-	0	0	-	-
Current portion of long-term debt	79,123	5,900	(72)	84,951	75,918	5,893	(72)	81,739
Variable rate debt classified as current	466,115	60,915	-	527,030	466,203	60,912	-	527,115
Due to affiliates	14,459	24,506	(38,965)	-	28	4,091	(4,119)	-
Other current liabilities	350,741	100,172	(33,412)	417,501	388,183	100,680	(26,302)	462,561
Total current liabilities	1,547,132	307,154	(72,726)	1,781,560	1,618,686	290,452	(32,803)	1,876,335
Long-term debt:								
Hospital revenue bonds	2,868,063	-	-	2,868,063	2,926,949	0	-	2,926,949
Notes payable and capital leases	121,298	546,203	(152,311)	515,190	121,896	547,127	(152,304)	516,719
	2,989,361	546,203	(152,311)	3,383,253	3,048,845	547,127	(152,304)	3,443,668
Other liabilities:								
Professional and general insurance liability reserves	57,941	87,688	-	145,629	57,290	88,819	-	146,109
Accrued retirement benefits	425,113	48,518	-	473,631	429,965	48,909	-	478,874
Other noncurrent liabilities	430,458	106,558	(50,596)	486,420	434,093	56,452	-	490,545
	913,512	242,764	(50,596)	1,105,680	921,348	194,180	-	1,115,528
Total liabilities	5,450,005	1,096,121	(275,633)	6,270,493	5,588,879	1,031,759	(185,107)	6,435,531
Net assets:								
Unrestricted	6,541,904	861,482	(3,448)	7,399,938	6,267,797	823,860	(3,448)	7,088,209
Temporarily restricted	625,494	31,030	-	656,524	597,449	29,977	-	627,426
Permanently restricted	297,092	17,723	-	314,815	292,582	17,582	-	310,164
Total net assets	7,464,490	910,235	(3,448)	8,371,277	7,157,828	871,419	(3,448)	8,025,799
Total liabilities and net assets	$12,914,495	$ 2,006,356	$ (279,081)	$14,641,770	$12,746,707	$ 1,903,178	$ (188,555)	$14,461,330

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 March 31, 2017				Three Months Ended March 31, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 1,761,782	$ 253,978	$ (57,381)	$ 1,958,379	$ 1,695,064	$ 220,589	$ (54,573)	$ 1,861,080
Provision for uncollectible accounts	(73,442)	(15,654)	-	(89,096)	(75,296)	(11,123)	-	(86,419)
Net patient service revenue less provision for uncollectible accounts	1,688,340	238,324	(57,381)	1,869,283	1,619,768	209,466	(54,573)	1,774,661
Other	172,370	72,045	(44,795)	199,620	142,180	62,494	(34,398)	170,276
Total unrestricted revenues	1,860,710	310,369	(102,176)	2,068,903	1,761,948	271,960	(88,971)	1,944,937
Expenses								
Salaries, wages, and benefits	1,070,247	153,841	(66,851)	1,157,237	1,037,022	145,856	(63,890)	1,118,988
Supplies	166,337	27,423	(135)	193,625	155,514	24,579	(85)	180,008
Pharmaceuticals	203,567	20,098	-	223,665	187,922	16,296	-	204,218
Purchased services and other fees	102,064	35,914	(11,852)	126,126	97,185	25,685	(2,531)	120,339
Administrative services	29,063	20,166	(5,178)	44,051	36,864	14,406	(6,075)	45,195
Facilities	67,785	17,586	(1,994)	83,377	70,435	18,585	(1,024)	87,996
Insurance	17,224	19,091	(16,166)	20,149	16,581	18,662	(15,366)	19,877
	1,656,287	294,119	(102,176)	1,848,230	1,601,523	264,069	(88,971)	1,776,621
Operating income before interest, depreciation, and amortization expenses	204,423	16,250	-	220,673	160,425	7,891	-	168,316
Interest	33,635	2,538	-	36,173	30,035	2,422	-	32,457
Depreciation and amortization	103,661	18,168	-	121,829	97,609	18,160	-	115,769
Operating income (loss) before special charges	67,127	(4,456)	-	62,671	32,781	(12,691)	-	20,090
Special charges	-	1,958	-	1,958	969	11,758	-	12,727
Operating income (loss)	67,127	(6,414)	-	60,713	31,812	(24,449)	-	7,363
Nonoperating gains and losses								
Investment return	224,206	18,476	-	242,682	10,477	2,994	-	13,471
Derivative gains (losses)	2,679	(623)	-	2,056	(33,600)	(743)	-	(34,343)
Other, net	2,574	537	-	3,111	328	(3,995)	-	(3,667)
Net nonoperating gains and losses	229,459	18,390	-	247,849	(22,795)	(1,744)	-	(24,539)
Excess (deficiency) of revenues over expenses	296,586	11,976	-	308,562	9,017	(26,193)	-	(17,176)

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)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2016	$ 6,676,408	$ 836,038	$ (3,448)	$ 7,508,998
Excess (deficiency) of revenues over expenses	9,017	(26,193)	-	(17,176)
Restricted gifts and bequests	14,589	392	-	14,981
Restricted net investment income	4,599	181	-	4,780
Net assets released from restrictions used for operations included in other unrestricted revenues	(6,847)	(741)	-	(7,588)
Contributions (to) from affiliates	(32,349)	32,349	-	-
Retirement benefits adjustment	(555)	-	-	(555)
Change in restricted net assets related to interest in foundations	-	(2)	-	(2)
Change in restricted net assets related to value of perpetual trusts	(1,138)	(402)	-	(1,540)
Net change in unrealized losses on nontrading investments	(666)	-	-	(666)
Other	(204)	(8,439)	-	(8,643)
Decrease in total net assets	(13,554)	(2,855)	-	(16,409)
Total net assets at March 31, 2016	$ 6,662,854	$ 833,183	$ (3,448)	$ 7,492,589
Total net assets at January 1, 2017	$ 7,157,828	$ 871,419	$ (3,448)	$ 8,025,799
Excess of revenues over expenses	296,586	11,976	-	308,562
Restricted gifts and bequests	26,801	802	-	27,603
Restricted net investment income	13,432	970	-	14,402
Net assets released from restrictions used for operations included in other unrestricted revenues	(7,213)	(681)	-	(7,894)
Transfers (to) from affiliates	(21,822)	21,822	-	-
Retirement benefits adjustment	(658)	-	-	(658)
Change in restricted net assets related to value of perpetual trusts	411	134	-	545
Foreign currency translation	(21)	3,694	-	3,673
Net change in unrealized losses on nontrading investments	(833)	-	-	(833)
Other	(21)	99	-	78
Increase in total net assets	306,662	38,816	-	345,478
Total net assets at March 31, 2017	$ 7,464,490	$ 910,235	$ (3,448)	$ 8,371,277

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)

	Three Months Ended March 31, 2017				Three Months Ended March 31, 2016			
	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	$ 306,662	$ 38,816	$ -	$ 345,478	$ (13,554)	$ (2,855)	$ -	$ (16,409)
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	658	-	-	658	555	-	-	555
Net realized and unrealized gains on investments	(229,625)	(19,172)	-	(248,797)	(7,218)	(2,212)	-	(9,430)
Depreciation and amortization	103,661	18,168	-	121,829	97,609	29,197	-	126,806
Provision for uncollectible accounts	73,442	15,654	-	89,096	75,296	11,123	-	86,419
Foreign currency translation loss (gain)	21	(3,694)	-	(3,673)	-	-	-	-
Restricted gifts, bequests, investment income, and other	(40,644)	(1,906)	-	(42,550)	(18,050)	(169)	-	(18,219)
Transfers to (from) affiliates	21,822	(21,822)	-	-	32,349	(32,349)	-	-
Accreted interest and amortization of bond premiums	(380)	3	-	(377)	(500)	(9)	-	(509)
Net (gain) loss in value of derivatives	(11,813)	-	-	(11,813)	34,999	(6,881)	-	28,118
Changes in operating assets and liabilities:								
Patient receivables	(72,554)	(41,166)	7,131	(106,589)	(165,476)	(8,483)	7,286	(166,673)
Other current assets	(52,422)	(66,622)	83,389	(35,655)	(9,621)	(63,670)	66,052	(7,239)
Other noncurrent assets	(758)	(163)	6	(915)	(162,917)	233	144,746	(17,938)
Accounts payable and other current liabilities	(55,609)	23,438	(39,923)	(72,094)	37,237	(5,778)	(28,416)	3,043
Other liabilities	(1,667)	48,584	(50,596)	(3,679)	970	57,170	(44,921)	13,219
Net cash provided by (used in) operating activities and net nonoperating gains and losses	40,794	(9,882)	7	30,919	(98,321)	(20,758)	144,747	25,668
Financing activities								
Proceeds from short-term borrowings, net	-	-	-	-	60,000	-	-	60,000
Proceeds from long-term borrowings	-	7	(7)	-	100,000	144,747	(144,747)	100,000
Payments for advance refunding of long-term debt	-	-	-	-	-	(148,260)	-	(148,260)
Principal payments on long-term debt	(60,376)	(1,014)	-	(61,390)	(59,739)	(6,604)	-	(66,343)
Debt issuance costs	-	-	-	-	(137)	-	-	(137)
Change in pledges receivable, trusts and interests in foundations	(6,912)	16	-	(6,896)	2,230	446	-	2,676
Restricted gifts, bequests, investment income, and other	40,644	1,906	-	42,550	18,050	169	-	18,219
Net cash (used in) provided by financing activities	(26,644)	915	(7)	(25,736)	120,404	(9,502)	(144,747)	(33,845)
Investing activities								
Expenditures for property and equipment	(102,444)	(16,680)	-	(119,124)	(114,365)	(22,883)	-	(137,248)
Net change in cash equivalents reported in long-term investments	(52,430)	17,252	-	(35,178)	55,874	52,817	-	108,691
Purchases of investments	(384,594)	(54,896)	-	(439,490)	(413,113)	(75,840)	-	(488,953)
Sales of investments	373,454	36,790	-	410,244	401,040	33,165	-	434,205
Transfers (to) from affiliates	(21,822)	21,822	-	-	(32,349)	32,349	-	-
Net cash (used in) provided by investing activities	(187,836)	4,288	-	(183,548)	(102,913)	19,608	-	(83,305)
Effect of exchange rate changes on cash	(21)	305		284	-	-	-	-
Increase (decrease) in cash and cash equivalents	(173,707)	(4,374)	-	(178,081)	(80,830)	(10,652)	-	(91,482)
Cash and cash equivalents at beginning of year	511,102	9,526	-	520,628	176,869	72,711	-	249,580
Cash and cash equivalents at end of period	$ 337,395	$ 5,152	$ -	$ 342,547	$ 96,039	$ 62,059	$ -	$ 158,098

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:

	Year Ended December 31			YTD March 31	
	2014	2015[3]	2016	2016	2017
Total Staffed Beds[1]	3,565	4,034	3,906	3,851	3,894
Percent Occupancy[1]	67.0%	67.9%	69.2%	69.8%	74.0%
Inpatient Admissions[1]					
Acute	140,596	146,990	161,674	40,864	42,674
Post-acute	11,908	11,779	12,487	3,203	3,087
Total	152,504	158,769	174,161	44,067	45,761
Patient Days[1]					
Acute	746,293	782,316	842,403	215,177	221,213
Post-acute	99,701	98,268	105,554	26,177	26,148
Total	845,994	880,584	947,957	241,354	247,361
Average Length of Stay					
Acute	5.28	5.30	5.21	5.28	5.18
Post-acute	8.38	8.30	8.48	8.30	8.50
Surgical Facility Cases					
Inpatient	55,515	56,311	59,760	15,155	15,535
Outpatient	130,706	137,139	147,850	36,448	37,459
Total	186,221	193,450	207,610	51,603	52,994
Emergency Room Visits	497,631	542,768	652,196	160,669	161,223
Outpatient Observations	49,724	49,237	58,385	13,602	15,628
Outpatient Evaluation and Management Visits[2]	3,508,030	3,742,901	4,194,593	1,045,624	1,117,171
Acute Medicare Case Mix Index - Health System	1.90	1.91	1.93	1.91	1.90
Acute Medicare Case Mix Index - Cleveland Clinic	2.47	2.47	2.53	2.49	2.58
Total Acute Patient Case Mix Index - Health System	1.81	1.81	1.84	1.83	1.84
Total Acute Patient Case Mix Index - Cleveland Clinic	2.37	2.36	2.44	2.40	2.48

(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 and Florida.
(3) 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:

	Year Ended December 31			YTD March 31	
	2014	2015	2016	2016	2017
Total Staffed Beds[1]	3,297	3,352	3,283	3,345	3,271
Percent Occupancy[1]	68.2%	69.6%	69.7%	71.3%	73.8%
Inpatient Admissions[1]					
Acute	134,704	138,287	138,741	35,264	35,524
Post-acute	9,827	9,740	9,487	2,456	2,287
Total	144,531	148,027	148,228	37,720	37,811
Patient Days[1]					
Acute	722,977	747,231	742,387	190,873	189,130
Post-acute	71,989	73,473	76,330	18,864	18,361
Total	794,966	820,704	818,717	209,737	207,491
Surgical Facility Cases					
Inpatient	53,764	53,839	53,922	13,716	13,730
Outpatient	127,903	132,800	135,849	33,331	31,955
Total	181,667	186,639	189,771	47,047	45,685
Emergency Room Visits	464,981	493,930	535,599	130,632	124,844
Outpatient Observations	46,409	45,687	50,416	11,542	13,047
Outpatient Evaluation and Management Visits[2]	3,508,030	3,742,901	4,194,593	1,045,624	1,117,171
Acute Medicare Case Mix Index	1.85	1.91	1.96	1.91	1.89
Total Acute Patient Case Mix Index	1.76	1.81	1.87	1.82	1.82

(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 and Florida.

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 March 31	
	2014	**2015[1]**	**2016**	**2016**	**2017**
Payor					
Managed Care and Commercial	43%	42%	39%	39%	38%
Medicare	43%	43%	44%	44%	46%
Medicaid	10%	12%	14%	14%	14%
Self-Pay & Other	4%	3%	3%	3%	2%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD March 31	
	2014	**2015**	**2016**	**2016**	**2017**
Payor					
Managed Care and Commercial	44%	42%	39%	40%	39%
Medicare	42%	43%	45%	44%	46%
Medicaid	10%	12%	13%	13%	13%
Self-Pay & Other	4%	3%	3%	3%	2%
Total	100%	100%	100%	100%	100%

[1] 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 March 31	
	2014	**2015**	**2016**	**2016**	**2017**
External Grants Earned					
Federal Sources	$97,327	$103,022	$108,253	$25,678	$28,999
Non-Federal Sources	88,284	81,796	87,883	20,724	21,317
Total	185,611	184,818	196,136	46,402	50,316
Internal Support	66,758	63,240	59,326	15,312	14,977
Total Sources of Support	$252,369	$248,058	$255,462	$61,714	$65,293

Key Ratios

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

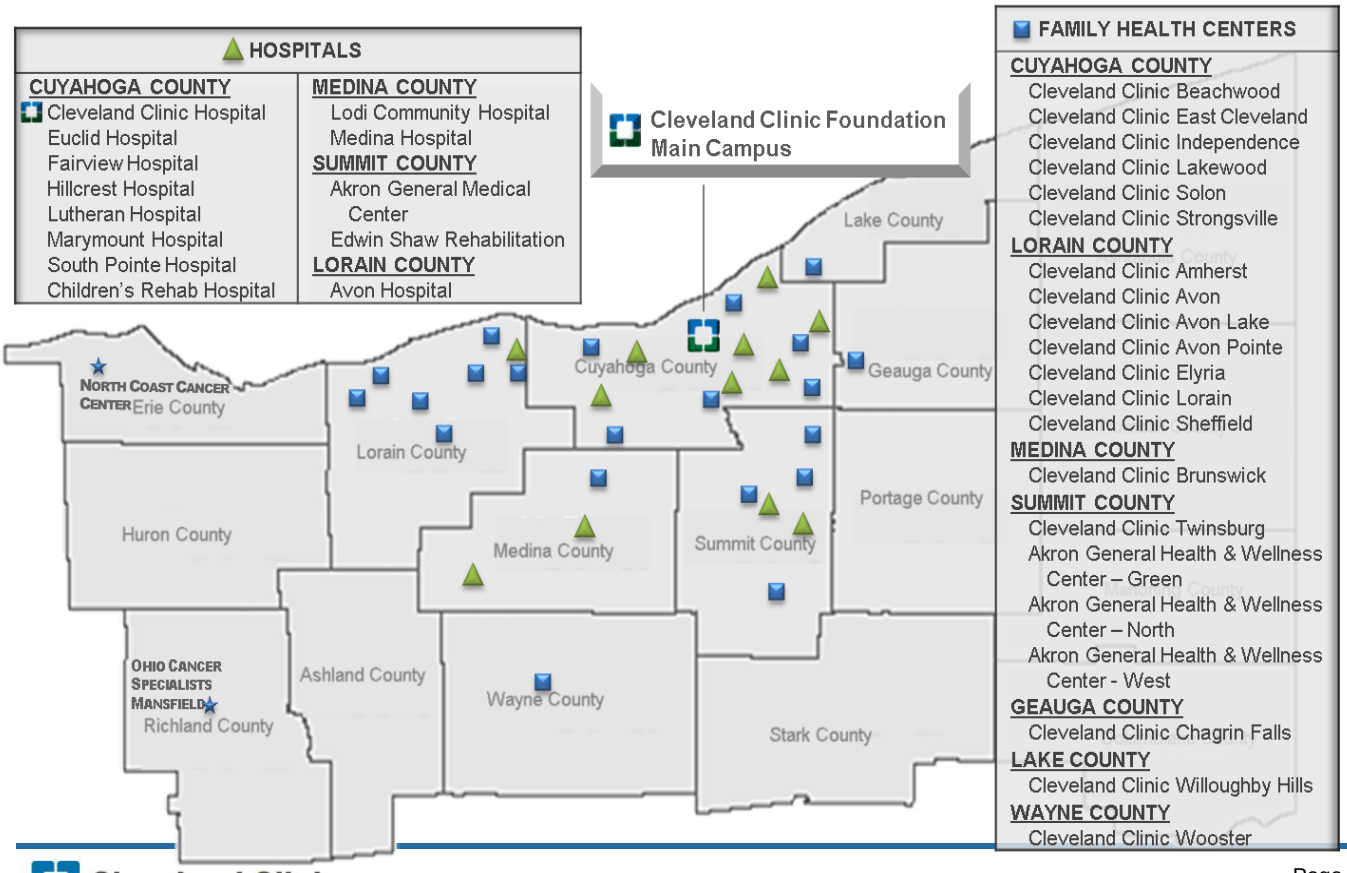
	Year Ended December 31			YTD March 31	
	2014	**2015**	**2016**	**2016**	**2017**
Liquidity ratios					
Days of cash on hand	377	347	349	328	351
Days of revenue in accounts receivable	47	47	51	53	52
Coverage ratios					
Cash to debt (%)	177.5	168.9	172.7	166.4	177.5
Maximum annual debt service coverage (x)	5.6	5.7	3.8	6.1	4.4
Interest expense coverage (x)	11.2	10.1	7.5	10.6	8.3
Debt to cash flow (x)	3.0	3.4	4.6	3.1	3.9
Leverage ratio					
Debt to capitalization (%)	36.1	36.5	36.4	36.3	35.1
Profitability ratios					
Operating margin (%)	7.0	6.7	3.0	0.4	2.9
Operating cash flow margin (%)	14.4	14.7	11.0	8.7	10.7
Excess margin (%)	10.2	8.5	6.2	(0.9)	13.3
Return on assets (%)	5.7	4.5	3.6	(0.5)	8.4

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 185 other countries in 2016. The System operates 14 hospitals with approximately 3,900 staffed beds and is the leading provider of healthcare services in northeast Ohio. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates 21 outpatient Family Health Centers, 10 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 March 31, 2017:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,274
Euclid Hospital	221
Fairview Hospital	451
Hillcrest Hospital	440
Lutheran Hospital	194
Marymount Hospital	230
Medina Hospital	133
South Pointe Hospital	173
Weston Hospital	155
	3,271
NON-OBLIGATED	
Akron General Medical Center	439
Avon Hospital	104
Children's Rehab Hospital	25
Edwin Shaw Rehabilitation Institute	35
Lodi Hospital	20
	623
HEALTH SYSTEM	3,894

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:

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.

In 2017, the Clinic was named one of the World's Most Ethical Companies by the Ethisphere Institute for the fifth consecutive year. Ethisphere Institute is a global leader in defining and advancing the standards of ethical business practices. The 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 was recognized by Becker's Hospital Review on its list of 100 great hospitals in America. The Becker's Hospital Review editorial team selected hospitals for inclusion based on analysis of several ranking and award agencies, including U.S. News and World Report's 2016-17 Honor Roll and specialty rankings, Centers for Medicare and Medicaid Services star ratings, Leapfrog grades, Truven Health Analytics top hospitals, Most Wired hospitals and Magnet accreditation. According to the Becker's Hospital Review website, hospitals on this list are industry leaders in innovation, quality patient care and clinical research and have received recognition across various publications and accrediting organizations.

The System was recognized by Fortune and Great Place to Work on its list of Best Workplaces in Healthcare. The System ranked 17th on the list, which was compiled based on a random sample of approximately 88,000 employees in healthcare organizations. Companies were evaluated on their organizations' leadership strength and integrity, pride in their work and organization, and the quality of relationships with co-workers. The leading healthcare workplaces outperformed their peers in a number of important areas, such as training, compensation, clear expectations from management and the emotional health of their workplaces.

Sydell & Arnold Miller Family Pavilion
Cleveland, Ohio

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 23 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 71 active Trustees and 12 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.

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.

In 2017, the responsibilities of the presidents of the System's acute-care hub hospitals — Hillcrest, Fairview and Akron — were expanded as they were appointed presidents of the East,

West and South regions, respectively. The three regional presidents are responsible for operations in all facilities (hospitals and family health centers) in their region. They are charged with the coordination and alignment of facilities and clinical programs. This structure allows all inpatient and outpatient services that are needed by the communities served to be available in each region. Each regional hospital will continue to have a president, and all hospital presidents will continue to report to J. Stephen Jones, MD, President of Regional Hospitals and Family Health Centers.

In May 2017, Toby Cosgrove, MD, President and Chief Executive Officer of the Clinic, announced that he will transition out of the top executive role later this year. His successor will be jointly selected by the Board of Directors and Board of Governors and that process is expected to be concluded in 2017. The Governance Committee has asked Dr. Cosgrove to continue on in an advisory role. Before becoming CEO in 2004, Dr. Cosgrove was a cardiac surgeon for nearly 30 years, performing 22,000 operations and earning an international reputation for expertise in valve repair. As President and CEO, Dr. Cosgrove has driven major initiatives that have gained international recognition, created best practices in healthcare, focused on patient outcomes and promoted patient experience. In keeping with its model as a physician-led institution, the Clinic's new President and CEO will be a practicing physician.

APPOINTMENTS

Margaret McKenzie, MD was appointed President of South Pointe Hospital. Dr. McKenzie succeeds Robert Juhasz, DO, who returned to full-time clinical practice within the organization. Dr. McKenzie joined the Clinic in 1995 and has most recently served as section head of General Obstetrics and Gynecology. Dr. McKenzie helped orchestrate the development of the Physician Diversity Scholars Program for Ohio University's Heritage College of Osteopathic Medicine at South Pointe Hospital and is an assistant professor of surgery at the Cleveland Clinic Lerner College of Medicine. She has co-authored two books and has written several articles in peer-reviewed journals.

Amy Merlino, MD, has been appointed Enterprise Clinical Medical Information Officer in the Information Technology Division. An obstetrics physician who specializes in maternal-fetal medicine, Dr. Merlino has been a leader in informatics since joining the staff in 2010. In her new position, Dr. Merlino will work with organizational and clinical business partners to optimize investment in technology and understand how technology impacts clinical care.

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 17 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.

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.

In November 2016, the System opened Avon Hospital (named "The Roseann Park Family Tower"), a new hospital located adjacent to the existing Family Health Center in Avon. Avon Hospital is an approximately 221,500 square foot five-story facility with capacity for 126 beds. The facility includes an intensive care unit, a cardiac catheterization lab, and expanded surgical and emergency services. The facility has been designed to leverage the latest in wireless capabilities and serve as a test site for evaluating future advancements in patient care. The cost of the new facility was approximately $160 million,

and construction took over two years to complete.

In March 2017, the System opened a new cancer outpatient building on the Clinic's main campus that unites multidisciplinary surgical, medical, and support services of the Cleveland Clinic Taussig Cancer Institute in one facility. The new building is adjacent to the Crile Outpatient Building and across from the Tomsich Pathology Laboratories Building. The 377,000 square foot, seven-story building houses 126 exam rooms, 98 infusion bays, 6 linear accelerators, 7 procedure rooms, a Gamma Knife suite and other cancer support functions. The building was designed to improve the patient experience by allowing natural light in the infusion bays and other treatment areas and helping patients receive treatment more quickly, efficiently and effectively. The cost of the new building was approximately $276 million, and construction took over two years to complete.

With the anticipated increase in patient services provided by the new cancer outpatient building, the System opened a 3,000 space structured parking garage in November 2016 located on the southeast corner of the main campus. The garage is 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 pedestrian bridge is expected to be completed in the second quarter of 2017.

The System also has the following expansion and improvement projects currently in progress:

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 2016, a newly renovated ultrasound department that includes adult and pediatric scanning that also opened in 2016, 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.

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 expanding its services through a new Family Health Center and Surgery Center that will be built 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. Design began in the second quarter of 2016, and construction is projected to be completed in the second quarter of 2018 with a total estimated cost of $32 million. The facility is being constructed and operated by a joint-venture partnership between Cleveland Clinic Florida and an external entity. Cleveland Clinic Florida will lease the facility upon completion of construction.

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 began in the first 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 16 treatment rooms. On the second and third floors, the facility will have 60 exam rooms. There will also be lab and imaging services to support operations at the facility. The facility is projected to cost approximately $34 million and is scheduled to open in the third quarter of 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.

Cleveland Clinic Akron General Hospital
Akron, Ohio

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 March 31, 2017, the Clinic has raised $1.1 billion 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, building renovation of vacated space, 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 78 companies, transacted more than 500 technology licenses, filed over 3,600 patent applications with over 1,200 issued patents, and acted on approximately 3,800 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 30 companies. GCIC celebrated its 10th anniversary in February 2017 and has supported the development of over 50 technologies and the creation of over 1,000 new jobs.

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.

The Clinic has recently created the Cleveland Clinic Ventures department, which will operate in tandem with Cleveland Clinic Innovations to turn medical breakthrough inventions into products and companies. The strategy of Cleveland Clinic

Ventures will be to maximize the success and sustainability of spin-offs and to raise funds that help get ideas to market through funding strategies and business model development. The collaboration between departments is expected to increase the Clinic's commercialization impact and to advance technologies to improve patient care.

ImageIQ, an imaging contract research organization specializing in advanced medical image acquisition, analysis and visualization that was spun out of Cleveland Clinic Innovations in 2011, was acquired by ERT in 2017. ERT is a global data and technology company that minimizes uncertainty and risk in clinical trials. The acquisition enables ERT to offer advanced clinical trial imaging analysis using cloud-based technology that delivers compliant data for use in clinical development with more accurate and verifiable imaging results than subjective readings commonly relied upon with standard scoring systems.

A team led by Andre Machado, MD, PhD performed the nation's first deep brain stimulation for stroke recovery. Enspire DBS, a portfolio company, was spun off in 2010 to fund and commercialize the method used in the procedure. NaviGate Cardiac Structures Inc., another portfolio company, reported the world's first successful implantation of a transcatheter tricuspid valve stent in a patient at the Clinic. The GATE™ tricuspid AVS has been developed and manufactured by NaviGate, which licensed the seminal technology from the Clinic.

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.

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.

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 one of 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 open in late 2017.

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. As part of a 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 at least the first five years after the member substitution. Initiatives include a new emergency department at Akron General Medical Center that started construction in the first quarter of 2017, 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 Statute and Limitations on Certain Physician Referrals regulation (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 cooperating with the appropriate government authorities on such possible violations. There is a probable 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, and potential fines and penalties that could be assessed. It is not possible to estimate the amount of 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 205-bed hospital with eight operating theatres. The System received approval from local authorities in January 2017 to begin conversion of the building into an advanced healthcare facility. The facility was fully vacated in the first quarter of 2017.

In addition to the London project, the System 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.

The System has set forth a strategy that embraces these fundamental shifts and positions 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 the Clinic's 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 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.

Efforts to transform care continue to constitute a major focus for the enterprise. Included among the activities within and across the clinical institutes are improvements in high reliability, access, care path development and implementation, and caregiver engagement. Of particular note is the initiative to build a focused business unit within the System for population management. This unit will be geared to ensure success in managing value-based contracts.

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.

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.

Leadership also is executing a focused growth strategy, domestically and internationally. A major emphasis of the domestic agenda is to assemble a distributed and rational network to execute against the payor strategy. Meanwhile, leadership continues to execute its international strategy to extend its unique model and capabilities more broadly and to meet its organizational goals. The Clinic also is engaged with a variety of non-provider entities to establish relationships that will bolster its transformation and growth activities.

Caregivers throughout the System 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

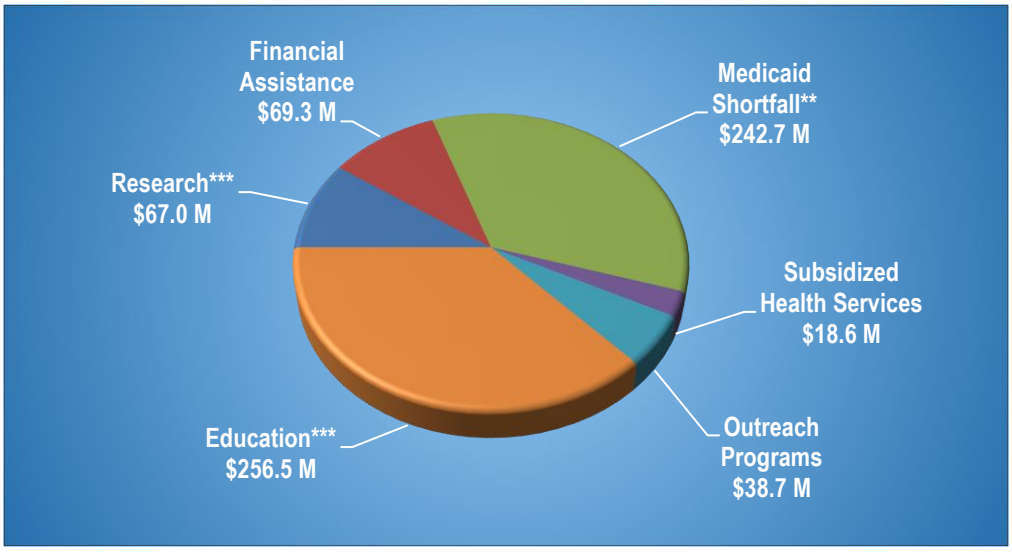
The Clinic and its hospital affiliates within the System are comprised of charitable, tax-exempt healthcare organizations. The System's mission includes addressing health service needs and providing benefits to the communities it serves. The tax-exempt members of the System must satisfy a community benefit 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.

Cleveland, Ohio Skyline

In 2015, the System provided $692.8 million in benefits to the communities it serves. Community benefit information for 2016 was not available at the time of issuance of this Management Discussion and Analysis. 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 System is providing more Medicaid services to more patients, which has increased the System's Medicaid shortfall in 2015.

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 (www.clevelandclinic.org/communitybenefit).

Community Health Needs Assessment

In 2016, 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.

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; and
- medical research and health professional education.

Information was also gathered from persons representing the broad interests of the community, including those with special knowledge or expertise in public health.

Key 2016 CHNA needs identified throughout the System include:

- chronic disease management (heart disease, cancer, diabetes, asthma, obesity);
- health conditions (mental health, poor birth outcomes, aging, chemical dependency)
- wellness (nutrition, exercise, tobacco cessation, preventative care);
- access to affordable health care;
- education (physician shortage); and
- medical research.

Hospital implementation strategies that address the health needs identified in the assessments have been developed by individual hospital leadership teams. The Implementation Strategy Reports (ISR's) will be added to the Clinic's website by mid-May in compliance with the regulatory requirements. The CHNA reports and implementation strategies for the System hospitals are available on the Clinic's website (www.clevelandclinic.org/CHNAReports).

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 51,000 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 on the Clinic's website (www.clevelandclinic.org/ungc).

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. This 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.

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.

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, promotes health equity, develops talent, and supports

caregivers to better serve our patients. Its programs include cultural competence training, diversity councils, employee resource groups, language enrichment, and internal and externally focused pipeline development programs.

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 2017 Leader in LGBTQ 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 third 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 in 2016. The African American ERG placed 1st, ClinicPride placed 12th, and SALUD placed 22nd. ERGs and Diversity Councils work to support the Cleveland Clinic strategy. They 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. 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.

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 $0.4 million for the three months ended March 31, 2017 and has recorded a total of $145 million since the inception of the program. Throughout the program, the System is expected to receive approximately $148 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. 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 2016, which is the eighth year the certification process was completed. The certification included 125 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 three months ended March 31, 2017 that have materially affected, or are likely to materially affect, the internal controls over financial reporting for the System.

INDUSTRY OUTLOOK

In December 2016, 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. Moody's expects operating cash flow growth of 0%-1% and patient volume growth of about 1%, which will help offset pressure from rising drug costs, pension liabilities and employment expenses. Hospitals are also experiencing rising co-pays and deductibles in employee health plans that is increasing bad debt. Moody's also notes that hospital mergers, acquisitions and affiliations will remain prevalent and can drive volume growth.

In May 2017, the U.S. House of Representatives approved legislation to repeal and replace major parts of the Affordable Care Act. The bill would need to pass the Senate before becoming law. In March 2017, Moody's released an opinion that the version of the legislation released by the U.S. House of Representatives in March to repeal and alter aspects of the Affordable Care Act will mostly likely be credit negative for hospitals. Moody's cited components of the initial legislation that are mostly likely to have a negative impact include the Medicaid expansion freeze in 2020, transition of federal Medicaid payments to a per-capita payment to the states and changes to how subsidies are calculated for people who buy coverage on the exchanges.

In January 2017, Standard & Poor's (S&P) maintained its stable outlook for the U.S. not-for-profit healthcare sector, despite seeing a sharp rise in legislative risk due to the potential repeal of the Affordable Care Act and related consequences as well as other aspects of the health care delivery system. S&P revised its outlook from negative to stable in September 2015. S&P indicated that 2015 financial medians and 2016 ratings and outlook experience continue to support their outlook for sector stability.

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.

PATIENT VOLUMES

The following table summarizes patient volumes for the System:

Utilization Statistics

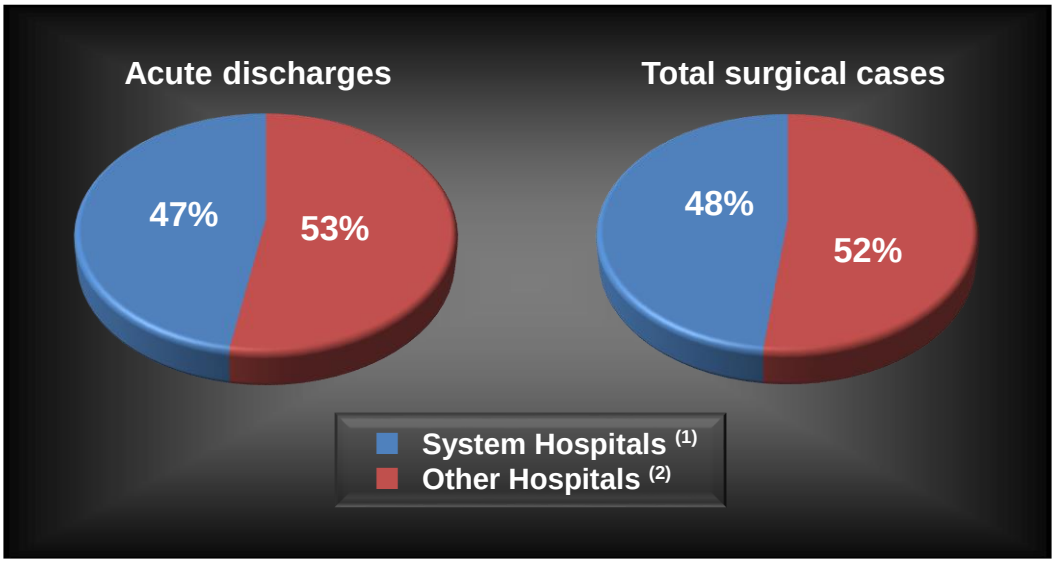
	For the quarter ended March 31			
	2017	2016	Variance	%
Inpatient admissions[1]				
Acute admissions	42,674	40,864	1,810	4.4%
Post-acute admissions	3,087	3,203	-116	-3.6%
	45,761	44,067	1,694	3.8%
Patient days[1]				
Acute patient days	221,213	215,177	6,036	2.8%
Post-acute patient days	26,148	26,177	-29	-0.1%
	247,361	241,354	6,007	2.5%
Surgical cases				
Inpatient	15,535	15,155	380	2.5%
Outpatient	37,459	36,448	1,011	2.8%
	52,994	51,603	1,391	2.7%
Emergency department visits	161,223	160,669	554	0.3%
Observations	15,628	13,602	2,026	14.9%
Clinic outpatient evaluation and management visits	1,117,171	1,045,624	71,547	6.8%

[1] Excludes newborns

Inpatient acute admissions for the System increased 4% in the first quarter of 2017 compared to the same period in 2016. The Clinic experienced a 1% decrease in acute admissions, and the regional hospitals, which include Akron General, collectively experienced a 7% increase in acute admissions, which resulted in a 4% increase at the System's facilities in northeast Ohio. The Florida facilities experienced a 4% increase in acute admissions over the same period. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio service area increased less than 1% in the first quarter of 2017 compared to the same period in 2016.

Total surgical cases for the System increased 3% in the first quarter of 2017 compared to the same period in 2016. The increase was driven by a 1% increase at the Clinic's main campus and family health centers and a 4% increase at the regional hospitals collectively, which resulted in a 3% increase at the System's facilities in northeast Ohio. The Florida facilities experienced a 4% increase in total surgical cases over the same period. According to data from the Center for Health Affairs, total surgical cases in northeast Ohio increased 5% in the first quarter of 2017 compared to the same period in 2016. The surgical mix of total surgical cases for the System for the first quarter of 2017 was 29% inpatient and 71% outpatient, which represents a slight shift from inpatient to outpatient compared to the surgical mix in the first quarter of 2016.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the three months ended March 31, 2017:



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 entities that are monitored by management. The System has established formal investment policies that support the System's investment objectives and provides an appropriate balance between return and risk.

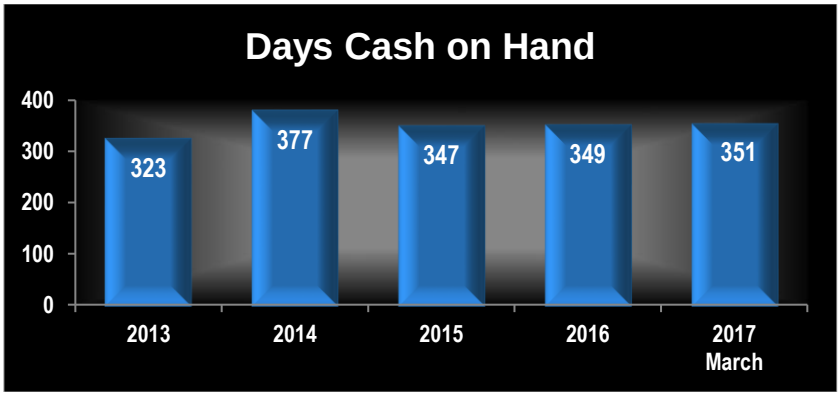
The following table sets forth the allocation of the System's cash and investments at March 31, 2017 and December 31, 2016:

Cash and Investments
(Dollars in thousands)

	March 31, 2017		December 31, 2016	
Cash and cash equivalents	$ 544,640	7%	$ 687,410	9%
Fixed income securities*	2,280,470	29%	2,109,524	27%
Marketable equity securities*	2,911,986	36%	2,785,380	35%
Alternative investments	2,263,298	28%	2,282,940	29%
Total cash and investments	$ 8,000,394	100%	$ 7,865,254	100%
Less restricted investments**	(909,308)		(868,367)	
Unrestricted cash and investments	$ 7,091,086		$ 6,996,887	
Days cash on hand	351		349	

* 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 March 31, 2017:

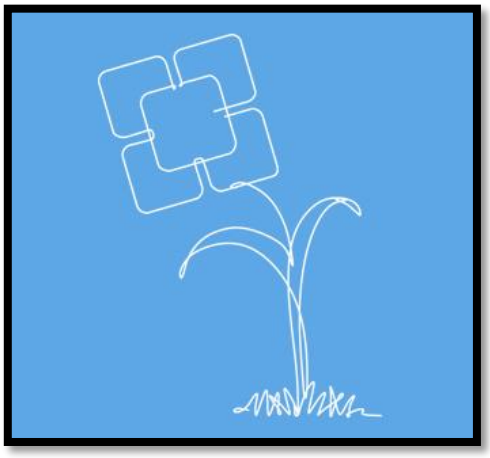


At March 31, 2017, total cash and investments for the System (including restricted investments) were $8.0 billion, an increase of $135 million from $7.9 billion at December 31, 2016. Cash inflows consist of cash provided by operating activities and related investment income of $280 million and a net increase in restricted gifts and income of $35 million. Cash inflows were offset by net capital expenditures of $119 million and scheduled principal payments on debt of $61 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $185.5 million at March 31, 2017, with an asset mix of 8% cash and short-term investments, 44% fixed-income securities, 33% equity investments and 15% 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 March 31, 2017 are $85.5 million of funds held by trustees. Funds held by trustees include $85.3 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. Investment objectives of funds held by the trustees are designed to preserve principal by investing in highly liquid cash or fixed-income investments. At March 31, 2017, the asset mix of funds held by trustees was 3% cash and short-term investments and 97% 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 March 31, 2017 and December 31, 2016 consist of the following:

Alternative Investments
(Dollars in thousands)

	March 31, 2017		December 31, 2016	
Hedge funds	$ 1,095,642	48%	$ 1,134,136	50%
Private equity/venture capital	729,104	32%	696,786	30%
Real estate	438,552	20%	452,018	20%
Total alternative investments	$ 2,263,298	100%	$ 2,282,940	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 3.6% for the first quarter of 2017, which is higher than the portfolio's benchmark gain of 2.8% and higher than investment gains of 0.2% experienced in the first quarter of 2016.

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

Investment Return
(Dollars in thousands)

	For the quarter ended March 31	
	2017	2016
Other unrestricted revenue:		
Interest income and dividends	$ 659	$ 614
Nonoperating gains and losses, net:		
Interest income and dividends	14,450	11,868
Net realized gains (losses) on sales of investments	24,784	(9,589)
Net change in unrealized gains on investments	192,554	38,228
Equity method income on alternative investments	18,771	(22,143)
Investment management fees	(7,877)	(4,893)
	242,682	13,471
Other changes in net assets:		
Net change in unrealized losses on nontrading investments	(833)	(666)
Investment income on restricted investments	14,402	4,780
Total investment return	$ 256,910	$ 18,199

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, 2016, the Plan had investments of $1.2 billion, which was 88% 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. As of March, 2017, the Plan's investments were comprised of 3% cash and cash equivalents, 51% fixed-income investments, 30% equities, and 16% alternative investments.

Long-term Debt

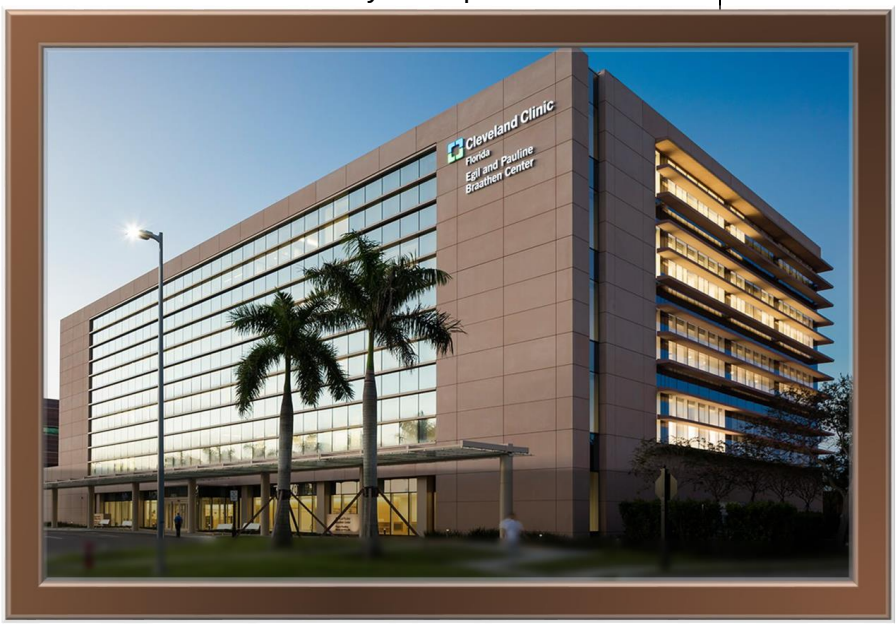
At March 31, 2017, outstanding bonds for the System totaled $3.429 billion, comprised of $2.645 billion (77%) of fixed-rate bonds, $11 million (<1%) of index-rate bonds and $773 million (23%) of variable-rate bonds. The System utilizes various interest rate swap derivative contracts to manage the risk 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 March 31, 2017 was $622 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 $390 million of the variable-rate bonds are directly placed with a financial institution or 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 $383 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 March 31, 2017, the System has $71.0 million of 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, 2016, are as follows (in millions): 2017 – $59.8; 2018 – $62.0; 2019 – $64.0; 2020 – $66.2; and 2021 – $69.2.



Egil and Pauline Braathen Center
Weston, Florida

Outstanding hospital revenue bonds for the System as of March 31, 2017 and December 31, 2016 consist of the following:

Hospital Revenue Bonds
(Dollars in thousands)

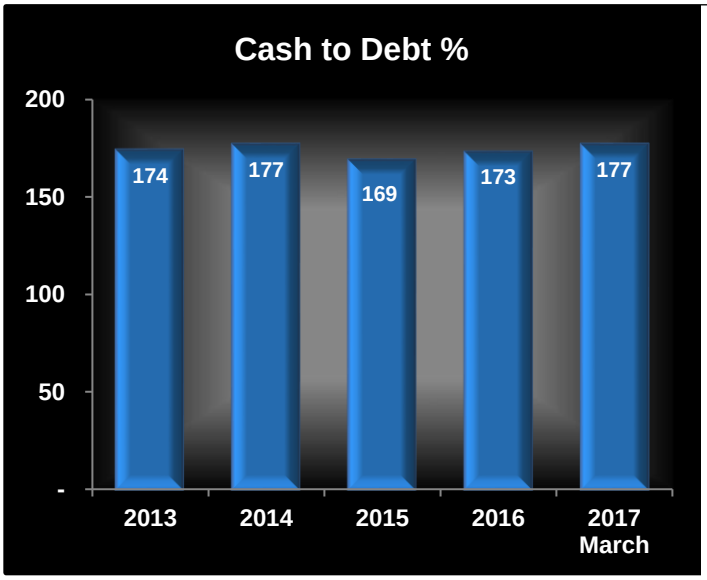
Series	Beneficiary	Type	Final Maturity	March 31 2017	December 31 2016
2016	CCHS Obligated Group	Fixed	2046	$ 325,000	$ 325,000
2016	CCHS Obligated Group	Variable	2026	17,370	17,370
2014	CCHS Obligated Group	Fixed	2114	400,000	400,000
2014A	CCHS Obligated Group	CP Notes	2044	70,955	70,955
2013A	CCHS Obligated Group	Fixed / Index	2042	73,150	73,150
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	63,135	63,135
2012A	CCHS Obligated Group	Fixed	2039	451,955	460,080
2011A	CCHS Obligated Group	Fixed	2032	160,605	172,030
2011B	CCHS Obligated Group	Fixed	2031	27,785	29,120
2011C	CCHS Obligated Group	Fixed	2032	157,945	170,995
2009A	CCHS Obligated Group	Fixed	2039	305,400	305,400
2009B	CCHS Obligated Group	Fixed	2039	351,365	366,215
2008A	CCHS Obligated Group	Fixed	2043	402,155	409,740
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	9,555	9,635
				$ 3,428,690	$ 3,485,140

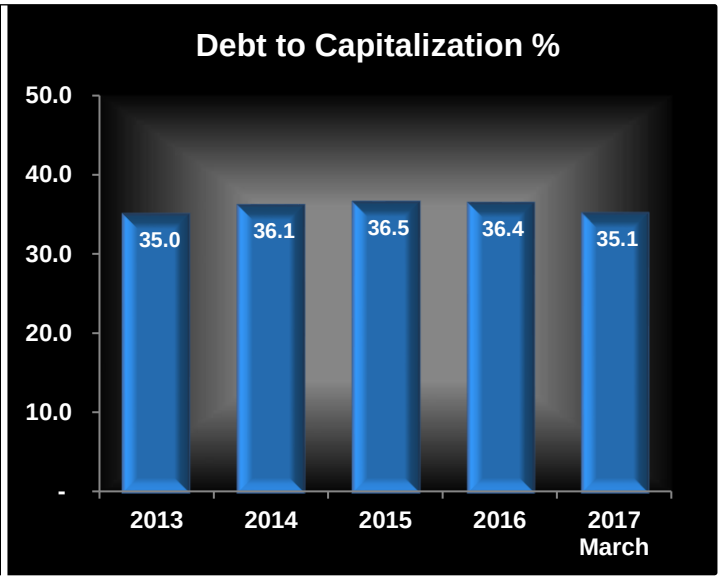
At December 31, 2016, the System has notes payable and capital leases totaling $538.8 million. Notes payable and capital leases include $381.2 million of notes payable with interest rates up to 6%, $60 million outstanding on a revolving credit facility and $97.6 million of capital lease liabilities primarily related to property and equipment.

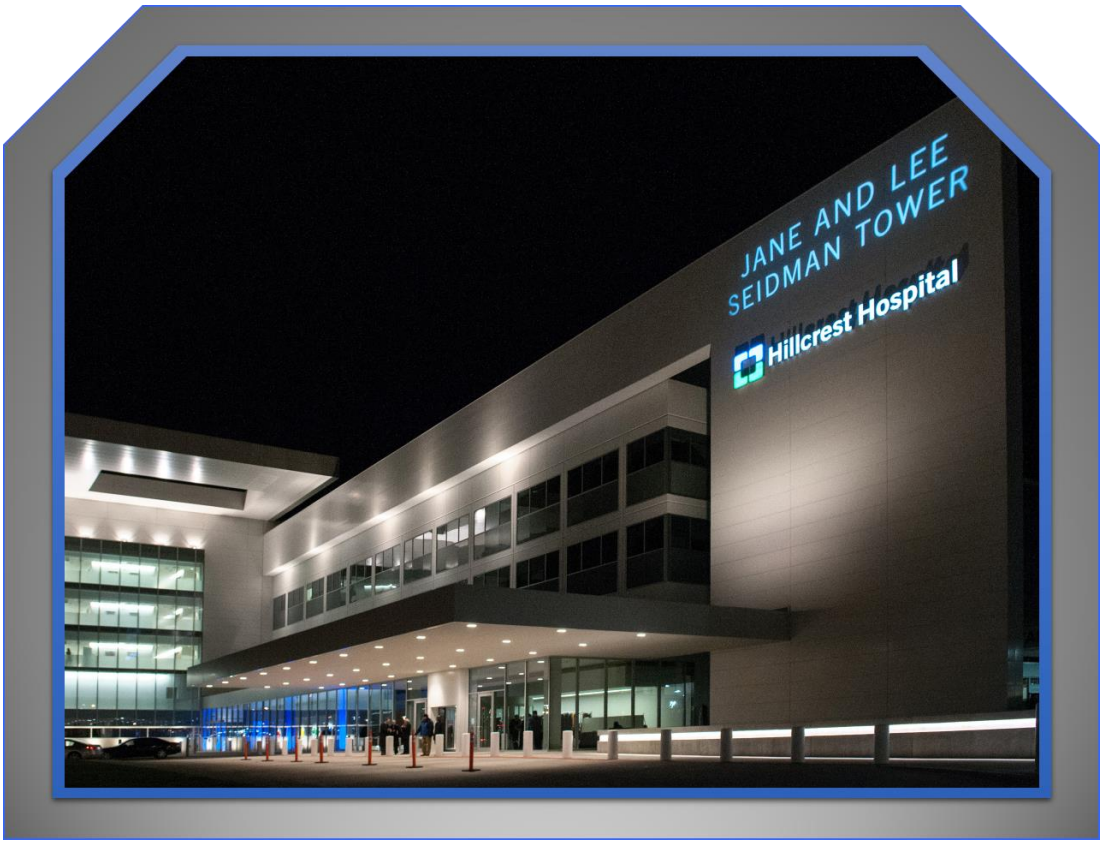
Included in notes payable is a term loan entered into by a Clinic subsidiary with a financial institution in October 2015 for a principal amount of $375 million. The proceeds of the term loan were used to finance the System's international business strategy. The term loan matures in 2018 and bears interest at a variable-rate based on the London Interbank Offered Rate (LIBOR) index plus an applicable spread. The Clinic provides a guarantee on the term loan.

The Clinic has 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 facility allows the System to enter into short-term loans that automatically renew throughout the term of the facility. 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 March 31, 2017 totaled $60.0 million and are recorded in notes payable in the consolidated balance sheets.

The following charts summarize cash-to-debt and debt-to-capitalization ratios for the System at December 31 for the last four years and March 31, 2017:







Jane and Lee Seidman Tower
Mayfield Heights, Ohio

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 March 31, 2017 and 2016

Operating income for the System in the first quarter of 2017 was $60.7 million, resulting in an operating margin of 2.9%, as compared to operating income of $7.4 million and an operating margin of 0.4% in the first quarter of 2016. The higher operating income primarily resulted from strong patient volumes, which contributed to a 6.4% increase in total unrestricted revenues. Operating expenses increased 3.6% in the first quarter of 2017 compared to the first quarter of 2016, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs and supplies. Nonoperating gains for the System were $247.8 million in the first quarter of 2017 compared to nonoperating losses of $24.6 million in the first quarter of 2016. The increase from the prior year was primarily due to 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 $308.6 million in the first quarter of 2017 compared to a deficiency of revenues over expenses of $17.2 million in the first quarter of 2016.

The System's net patient service revenue increased $97.3 million (5.2%) in the first quarter of 2017 compared to the same period in 2016. The System experienced increases in inpatient acute admissions of 4.4%, total surgical cases of 2.7%, outpatient evaluation and management visits of 6.8% and emergency department visits of 0.3% in the first quarter of 2017 compared to the first quarter of 2016. 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 1.6% in the first quarter of 2017 compared to the same period in 2016. The System has experienced a corresponding decrease in managed care and commercial gross revenues as a percentage of total gross patient 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 2017. 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 $2.7 million (3.1%) in the first quarter of 2017 compared to the same period in 2016. The increase is primarily attributable to increases in net patient service revenue and in deductible and copayment balances. The growth in high copayment and deductible health plans is an industry trend that will likely continue to accelerate. 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 are generally more difficult to collect than traditional insurance payors. The System has implemented various initiatives to collect patient responsibility balances and continues to monitor the changing healthcare environment and the accelerating shift in reimbursement models that are expected to result in declining reimbursement from governmental and commercial payors. The System is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare more affordable to patients.

Other unrestricted revenues increased $29.3 million (17.2%) in the first quarter of 2017 compared to the same period in 2016. The increase in other unrestricted revenues was primarily due to a $16.2 increase in management service contract revenue, a $5.2 million increase in outpatient pharmacy revenue, a $3.1 million increase in revenue related to research and education grants, a $2.8 million increase related to the sale of a CCF Innovations spin-off company and a $1.5 million increase in unrestricted gifts and assets released from restriction.

Total operating expenses increased $70.6 million (3.6%) in the first quarter of 2017 compared to the same period in 2016. Notable increases in expenses were experienced in salaries, wages and benefits, pharmaceutical costs and supplies, which is partially due to higher patient volumes. 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 $38.3 million (3.4%) in the first quarter of 2017 compared to the same period in 2016. Salaries, excluding benefits, increased $36.6 million (3.9%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2016 and a 3.2% increase in average full-time equivalent employees in the first quarter of 2017 compared to the same period in 2016. Benefit costs increased $1.7 million (0.9%) during the same period. Defined contribution expenses increased $3.3 million and FICA expenses increased $3.3 million primarily due to the increase in salaries and full-time equivalent employees. These increases were offset by a $1.9 million decrease in employee health care costs.

Supplies expense increased $13.6 million (7.6%) in the first quarter of 2017 compared to the same period in 2016. The System experienced a $13.3 million increase in implantables and other medical supplies primarily due to higher surgical volumes and a $0.3 million increase in non-medical supplies primarily due to increased minor equipment and software costs.

Pharmaceutical costs increased $19.4 million (9.5%) in the first quarter of 2017 compared to the same period in 2016. 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 $4.8 million in the first quarter of 2017 compared to the same period in 2016. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $5.8 million (4.8%) in the first quarter of 2017 compared to the same period in 2016. The increase in purchased service expenses was primarily due to a $2.9 million increase in purchased medical services primarily related to external lab services and a $2.9 million increase in various purchased non-medical service costs related to certain System projects and initiatives.

Administrative services decreased $1.1 million (2.5%) in the first quarter of 2017 compared to the same period in 2016. The decrease in same facility administrative services was primarily due to a $1.5 million decrease in consulting fees and professional services offset by a $0.2 increase in expenses related to research projects.

Facilities expense decreased $4.6 million (5.2%) in the first quarter of 2017 compared to the same period in 2016. The decrease in facilities expense was primarily due to decreases in repairs and maintenance and utility costs across the System.

Insurance expense increased $0.3 million (1.4%) in the first quarter of 2017 compared to the same period in 2016. The increase in insurance expense was primarily due to an increase 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 $3.7 million (11.4%) in the first quarter of 2017 compared to the same period in 2016. The System has experienced higher interest rates on its variable-rate bonds and notes payable in the first quarter of 2017 compared to 2016. In addition, the System issued $325.0 million of fixed-rate private placement debt in the third quarter of 2016 that bears interest at a fixed rate of 3.35%. This increase in debt was partially offset by $61.4 million of principal payments on bonds, notes and capital leases in the first quarter of 2017, which reduced the amount of interest due on outstanding debt.

Depreciation and amortization expenses increased $6.1 million (5.2%) in the first quarter of 2017 compared to the same period in 2016. Changes in depreciation include property, plant and equipment that was fully depreciated in 2016, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2017.

Special charges decreased $10.7 million (84.6%) in the first quarter of 2017 compared to the same period in 2016. The System incurred and recorded $2.0 million and $12.7 million of special charges in the first quarters of 2017 and 2016, respectively. Special charges in the first quarter of 2017 and 2016 are 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 $247.8 million in the first quarter of 2017 compared to a net loss of $24.6 million in the first quarter of 2016, resulting in an unfavorable variance of $272.4 million. Investment returns were favorable by $229.2 million in the first quarter of 2017 compared to the same period in 2016. The System's long-term investment portfolio reported investment gains of 3.6% for the first quarter of 2017, which is higher than the portfolio's benchmark gain of 2.8% and higher than investment gains of 0.2% experienced in the first quarter of 2016. Derivative losses were favorable by $36.4 million in the first quarter of 2017 compared to the same period in 2016. 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. The System also experienced a $2.9 million favorable variance in nonoperating gains related to net periodic pension cost. The System adopted Accounting Standard Update 2017-07 in the first quarter of 2017 and retrospectively adjusted the statement of operations for the first quarter of 2016. The impact of adoption on the statement of operations for the first quarter of 2016 was a reclassification of $0.1 million that increased other nonoperating gains and losses, with a corresponding increase to salaries, wages and

benefits and decrease in operating income. Nonoperating gains and losses in the first quarter of 2016 include a $3.9 million loss on extinguishment of debt related to the defeasance and redemption of Akron General bonds.

BALANCE SHEET – MARCH 31, 2017 COMPARED TO DECEMBER 31, 2016

Patient accounts receivable, net of allowances for uncollectible accounts, increased $17.5 million (1.7%) from December 31, 2016 to March 31, 2017. 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 2017. The System has also 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 are generally more difficult to collect than traditional insurance payors. Patient responsibility accounts receivable also tend to be seasonally higher in the first quarter as many insurance plans have annual deductible requirements. 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 51 days at December 31, 2016 to 52 days at March 31, 2017.

Investments for current use includes assets held for self-insurance that will be used to pay the current portion of estimated claim liabilities. There was no change in these investments in the first quarter of 2017.

Other current assets increased $38.5 million (9.7%) from December 31, 2016 to March 31, 2017. The increase in other current assets was primarily due to a $23.4 million increase in prepaid expenses, a $12.6 million increase in receivables related to the timing of receipts for various Medicare and Medicaid programs and a $7.5 million increase receivables related to research projects.

Unrestricted long-term investments increased $272.3 million (4.2%) from December 31, 2016 to March 31, 2017. The increase was primarily due to positive unrestricted investment returns of $242.7 million in the first quarter of 2017. Total unrestricted cash, cash equivalents and long-term investments increased $94.2 million from December 31, 2016 to March 31, 2017. The System experienced $279.7 million of net positive cash flow from operations and investment income in the first quarter of 2017, which was partially offset by net capital expenditures of $119.1 million and principal payments on long-term debt of $61.4 million.

Funds held by trustees increased $9.6 million (12.7%) from December 31, 2016 to March 31, 2017. The increase in funds held by trustees is primarily due to a $9.7 million increase of collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance increased $5.2 million (4.1%) from December 31, 2016 to March 31, 2017. The increase in self-insurance assets is primarily due to investment gains experienced in the System's captive insurance subsidiary.

Donor restricted assets increased $26.1 million (4.3%) from December 31, 2016 to March 31, 2017. The increase in donor restricted assets was primarily from investment gains on restricted investments and the receipt of donor restricted

gifts in excess of expenditures from restricted funds.

Net property, plant and equipment decreased $15.2 million (0.3%) from December 31, 2016 to March 31, 2017. The System had net expenditures for property, plant and equipment of $119.1 million, which excludes foreign currency translation gains of $3.4 million and is offset by depreciation expense of $121.3 million. Capital expenditures in 2017 include amounts paid on retainage liabilities recorded at December 31, 2016 and exclude assets acquired through capital lease arrangements. Retainage liabilities decreased $20.8 million and new capital leases totaled $4.5 million in the first quarter of 2017. 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 $4.5 million (0.7%) from December 31, 2016 to March 31, 2017. The increase in noncurrent assets was primarily due to a $3.4 million increase in long-term pledge receivables and a $0.7 million increase in the value of perpetual and charitable trusts.

Accounts payable decreased $93.5 million (19.4%) from December 31, 2016 to March 31, 2017. The decrease in accounts payable was primarily attributable to the timing of payment processing for trade payables, a $20.8 million decrease in retainage liabilities and a $13.3 million decrease in outstanding checks.

Compensation and amounts withheld from payroll increased $40.7 million (12.6%) from December 31, 2016 to March 31, 2017. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $3.2 million (3.9%) from December 31, 2016 to March 31, 2017. The increase in current portion of long-term debt primarily relates to reclassifications of regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments of $61.4 million made in the first quarter of 2017.

Variable rate debt classified as current decreased $0.1 million (0.0%) from December 31, 2016 to March 31, 2017. 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 decrease in variable rate debt classified as current in the first quarter of 2017 is due to regularly scheduled principal payments.

Other current liabilities decreased $45.1 million (9.7%) from December 31, 2016 to March 31, 2017. The decrease in other current liabilities is primarily due to a $31.7 million decrease in accrued interest payable related to fixed-rate bonds that pay interest semi-annually in January and July of each year, a $4.7 million decrease in international deferred management revenue, a $4.3 million decrease in the fair value of the System's foreign exchange derivative contracts and a $4.3 million decrease in deferred revenue related to research projects.

Hospital revenue bonds decreased $58.9 million (2.0%) from December 31, 2016 to March 31,

2017. The decrease in hospital revenue bonds is primarily due to the reclassification of regularly scheduled principal payments from long-term to current for bond payments due within one year.

Notes payable and capital leases decreased $1.5 million (0.3%) from December 31, 2016 to March 31, 2017. The decrease is primarily due to the reclassification of regularly scheduled principal payments from long-term to current, offset by $4.5 million in new capital leases recorded in the first quarter of 2017.

Professional and general insurance liability reserves decreased $0.5 million (0.3%) from December 31, 2016 to March 31, 2017. The decrease is due to claim liability payments in excess of expenses recorded for the accrual of current year claim estimates.

Accrued retirement benefits decreased $5.2 million (1.1%) from December 31, 2016 to March 31, 2017. The change in accrued retirement benefits is comprised of a $5.0 million decrease in the System's defined benefit pension plan liabilities and a $0.2 million decrease in other postretirement benefit liabilities. The decrease in defined benefit pension plan liabilities is primarily due to negative net periodic pension cost, which is based on actuarial estimates resulting from the expected return on plan assets in excess of interest cost incurred on plan obligations.

Other noncurrent liabilities decreased $4.1 million (0.8%) from December 31, 2016 to March 31, 2017. The decrease in other noncurrent liabilities is primarily due to a $6.8 million decrease in in derivative liabilities associated with changes in the fair value of the System's interest rate swap derivative contracts, which was offset by a $1.8 million increase in long-term deferred gift annuity liabilities.

Total net assets increased $345.5 million (4.3%) from December 31, 2016 to March 31, 2017. Unrestricted net assets increased $311.7 million (4.4%) primarily due to an excess of revenues over expenses of $308.6 million and $3.7 million of foreign currency translation gains. Temporarily restricted net assets increased $29.1 million (4.6%), primarily due to $23.5 million in temporarily restricted gifts and $14.4 million in net investment income offset by $8.8 million in assets released from restrictions. Permanently restricted net assets increased $4.7 million (1.5%) primarily due to $4.1 million of permanently restricted gifts and a $0.6 million increase in the value of perpetual trusts.

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.