Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended December 31, 2017

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	December 31	
	2017	**2016**
Assets		
Current assets:		
Cash and cash equivalents	**$ 241,227**	$ 520,628
Patient receivables, net of allowances for uncollectible accounts of $194,159 in 2017 and $186,241 in 2016	**1,012,903**	1,059,171
Investments for current use	**154,971**	52,126
Other current assets	**374,726**	396,892
Total current assets	**1,783,827**	2,028,817
Investments:		
Long-term investments	**7,729,697**	6,476,259
Funds held by trustees	**69,234**	75,892
Assets held for self-insurance	**159,802**	128,128
Donor-restricted assets	**717,410**	612,221
	8,676,143	7,292,500
Property, plant, and equipment, net	**4,699,697**	4,512,078
Other assets:		
Pledges receivable, net	**151,019**	150,709
Trusts and interests in foundations	**80,643**	67,219
Other noncurrent assets	**475,010**	410,007
	706,672	627,935
Total assets	**$ 15,866,339**	$ 14,461,330

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	December 31	
	2017	**2016**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 503,691**	$ 482,427
Compensation and amounts withheld from payroll	**345,446**	322,493
Current portion of long-term debt	**457,813**	81,739
Variable rate debt classified as current	**573,270**	527,115
Other current liabilities	**438,662**	462,561
Total current liabilities	**2,318,882**	1,876,335
Long-term debt:		
Hospital revenue bonds	**2,861,438**	2,926,949
Notes payable and capital leases	**134,840**	516,719
	2,996,278	3,443,668
Other liabilities:		
Professional and general liability insurance reserves	**147,327**	146,109
Accrued retirement benefits	**492,833**	478,874
Other noncurrent liabilities	**567,566**	490,545
	1,207,726	1,115,528
Total liabilities	**6,522,886**	6,435,531
Net assets:		
Unrestricted	**8,346,649**	7,088,209
Temporarily restricted	**662,189**	627,426
Permanently restricted	**334,615**	310,164
Total net assets	**9,343,453**	8,025,799
Total liabilities and net assets	**$ 15,866,339**	$ 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 December 31	
	2017	**2016**
Unrestricted revenues		
Net patient service revenue	**$ 1,956,080**	$ 1,954,809
Provision for uncollectible accounts	**(53,112)**	(60,703)
Net patient service revenue less provision for uncollectible accounts	**1,902,968**	1,894,106
Other	**221,912**	208,374
Total unrestricted revenues	**2,124,880**	2,102,480
Expenses		
Salaries, wages, and benefits	**1,117,742**	1,097,354
Supplies	**207,707**	193,666
Pharmaceuticals	**247,726**	225,992
Purchased services and other fees	**140,776**	130,769
Administrative services	**62,269**	56,492
Facilities	**82,879**	87,700
Insurance	**13,560**	10,801
	1,872,659	1,802,774
Operating income before interest, depreciation, and amortization expenses	**252,221**	299,706
Interest	**32,990**	36,288
Depreciation and amortization	**118,455**	123,377
Operating income before special charges	**100,776**	140,041
Special charges	**1,072**	2,734
Operating income	**99,704**	137,307
Nonoperating gains and losses		
Investment return	**248,375**	38,545
Derivative gains	**4,217**	44,858
Other, net	**(41,439)**	(104,644)
Net nonoperating gains (losses)	**211,153**	(21,241)
Excess of revenues over expenses	**310,857**	116,066

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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 October 1, 2016	$ 6,987,798	$ 607,592	$ 302,702	$ 7,898,092
Excess of revenues over expenses	116,066	–	–	116,066
Donated capital and assets released from restrictions for capital purposes	15,742	(15,981)	–	(239)
Gifts and bequests	–	48,609	4,555	53,164
Net investment income	–	3,350	–	3,350
Net assets released from restrictions used for operations included in other unrestricted revenues	–	(15,836)	–	(15,836)
Retirement benefits adjustment	(16,125)	–	–	(16,125)
Change in interests in foundations	–	97	–	97
Change in value of perpetual trusts	–	–	2,907	2,907
Foreign currency translation	(15,961)	–	–	(15,961)
Other	689	(405)	–	284
Increase in net assets	100,411	19,834	7,462	127,707
Balances at December 31, 2016	$ 7,088,209	$ 627,426	$ 310,164	$ 8,025,799
Balances at October 1, 2017	**$ 8,024,850**	**$ 634,704**	**$ 325,965**	**$ 8,985,519**
Excess of revenues over expenses	**310,857**	–	–	**310,857**
Donated capital and assets released from restrictions for capital purposes	**9,864**	**(9,864)**	–	**–**
Gifts and bequests	–	**34,397**	**7,821**	**42,218**
Net investment income	–	**16,893**	–	**16,893**
Net assets released from restrictions used for operations included in other unrestricted revenues	–	**(15,213)**	–	**(15,213)**
Retirement benefits adjustment	**(1,398)**	–	–	**(1,398)**
Change in interests in foundations	–	**1,411**	–	**1,411**
Change in value of perpetual trusts	–	–	**829**	**829**
Foreign currency translation	**2,189**	–	–	**2,189**
Other	**287**	**(139)**	–	**148**
Increase in net assets	**321,799**	**27,485**	**8,650**	**357,934**
Balances at December 31, 2017	**$ 8,346,649**	**$ 662,189**	**$ 334,615**	**$ 9,343,453**

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Year Ended December 31	
	2017	**2016**
Unrestricted revenues		
Net patient service revenue	**$ 7,794,551**	$ 7,551,066
Provision for uncollectible accounts	**(296,469)**	(301,694)
Net patient service revenue less provision for uncollectible accounts	**7,498,082**	7,249,372
Other	**908,920**	787,835
Total unrestricted revenues	**8,407,002**	8,037,207
Expenses		
Salaries, wages, and benefits	**4,565,140**	4,430,982
Supplies	**793,365**	749,073
Pharmaceuticals	**957,045**	862,697
Purchased services and other fees	**533,045**	506,107
Administrative services	**198,863**	196,958
Facilities	**334,371**	343,377
Insurance	**61,060**	66,746
	7,442,889	7,155,940
Operating income before interest, depreciation, and amortization expenses	**964,113**	881,267
Interest	**140,824**	136,105
Depreciation and amortization	**487,240**	476,305
Operating income before special charges	**336,049**	268,857
Special charges	**5,491**	25,618
Operating income	**330,558**	243,239
Nonoperating gains and losses		
Investment return	**896,139**	404,191
Derivative losses	**(2,305)**	(22,824)
Other, net	**(74,078)**	(111,099)
Net nonoperating gains	**819,756**	270,268
Excess of revenues over expenses	**1,150,314**	513,507

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

($ in thousands)

Changes in Net Assets

	Net Assets			
		Temporarily	Permanently	
	Unrestricted	Restricted	Restricted	Total
Balances at January 1, 2016	$ 6,627,406	$ 586,276	$ 295,316	$ 7,508,998
Excess of revenues over expenses	513,507	–	–	513,507
Donated capital and assets released from restrictions for capital purposes	23,448	(22,683)	–	765
Gifts and bequests	–	84,256	16,939	101,195
Net investment income	–	24,451	–	24,451
Net assets released from restrictions used for operations included in other unrestricted revenues	–	(45,292)	–	(45,292)
Retirement benefits adjustment	(17,789)	–	–	(17,789)
Change in interests in foundations	–	432	–	432
Change in value of perpetual trusts	–	–	(2,091)	(2,091)
Foreign currency translation	(59,181)	–	–	(59,181)
Other	818	(14)	–	804
Increase in net assets	460,803	41,150	14,848	516,801
Balances at December 31, 2016	7,088,209	627,426	310,164	8,025,799
Excess of revenues over expenses	**1,150,314**	–	–	**1,150,314**
Donated capital and assets released from restrictions for capital purposes	**81,871**	**(81,871)**	–	**–**
Gifts and bequests	–	**98,555**	**22,116**	**120,671**
Net investment income	–	**55,112**	–	**55,112**
Net assets released from restrictions used for operations included in other unrestricted revenues	–	**(41,675)**	–	**(41,675)**
Retirement benefits adjustment	**(3,373)**	–	–	**(3,373)**
Change in interests in foundations	–	**5,047**	–	**5,047**
Change in value of perpetual trusts	–	–	**2,335**	**2,335**
Foreign currency translation	**29,301**	–	–	**29,301**
Other	**327**	**(405)**	–	**(78)**
Increase in net assets	**1,258,440**	**34,763**	**24,451**	**1,317,654**
Balances at December 31, 2017	**$ 8,346,649**	**$ 662,189**	**$ 334,615**	**$ 9,343,453**

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Year Ended December 31	
	2017	**2016**
Operating activities and net nonoperating gains and losses		
Increase in net assets	**$ 1,317,654**	$ 516,801
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Loss on extinguishment of debt	**46,159**	3,925
Retirement benefits adjustment	**3,373**	17,789
Net realized and unrealized gains on investments	**(897,841)**	(382,146)
Depreciation and amortization	**490,663**	491,292
Provision for uncollectible accounts	**296,469**	301,694
Foreign currency translation (gain) loss	**(29,301)**	59,181
Donated capital	**–**	(765)
Restricted gifts, bequests, investment income, and other	**(183,165)**	(123,987)
Amortization of bond premiums and debt issuance costs	**(3,106)**	(1,657)
Net gain in value of derivatives	**(26,509)**	(8,835)
Changes in operating assets and liabilities:		
Patient receivables	**(250,201)**	(410,561)
Other current assets	**10,173**	31,113
Other noncurrent assets	**(66,487)**	(58,559)
Accounts payable and other current liabilities	**16,404**	91,924
Other liabilities	**92,395**	8,928
Net cash provided by operating activities and net nonoperating gains and losses	**816,680**	536,137
Financing activities		
Proceeds from long-term borrowings	**1,118,137**	502,448
Payments for advance refunding and redemption of long-term debt	**(1,110,120)**	(148,260)
Principal payments on long-term debt	**(84,257)**	(127,011)
Debt issuance costs	**(8,173)**	(949)
Change in pledges receivable, trusts, and interests in foundations	**(1,206)**	(10,203)
Restricted gifts, bequests, investment income, and other	**183,165**	123,987
Net cash provided by financing activities	**97,546**	340,012
Investing activities		
Expenditures for property and equipment	**(607,720)**	(664,703)
Proceeds from sale of property and equipment	**1,486**	1,585
Net change in cash equivalents reported in long-term investments	**(362,513)**	146,064
Purchases of investments	**(2,441,368)**	(2,757,671)
Sales of investments	**2,215,234**	2,671,903
Net cash used in investing activities	**(1,194,881)**	(602,822)
Effect of exchange rate changes on cash	**1,254**	(2,279)
(Decrease) increase in cash and cash equivalents	**(279,401)**	271,048
Cash and cash equivalents at beginning of year	**520,628**	249,580
Cash and cash equivalents at end of year	**$ 241,227**	$ 520,628

See notes to unaudited consolidated financial statements.

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. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2017.

1. 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 13 hospitals with approximately 3,800 staffed beds. Twelve 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, and 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 364 staffed beds.

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

2. 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.

2. Accounting Policies (continued)

The System adopted ASU 2014-09 on January 1, 2018 using the modified retrospective method of transition. The System's process for implementation began with a preliminary evaluation of ASU 2014-09 and considered subsequent interpretations by the FASB Transition Resource Group for Revenue Recognition and the American Institute of Certified Public Accountants. The System performed an analysis of revenue streams and transactions under ASU 2014-09. In particular, for net patient service revenue, the System performed an analysis into the application of the portfolio approach as a practical expedient to group patient contracts with similar characteristics, such that revenue for a given portfolio would not be materially different than if it were evaluated on a contract-by-contract basis. Upon adoption, the majority of what is currently classified as provision for uncollectible accounts and presented as a reduction to net patient service revenue on the consolidated statements of operations and changes in net assets will be treated as a price concession that reduces the transaction price, which is reported as net patient service revenue. The new standard also requires enhanced disclosures related to the disaggregation of revenue and significant judgments made in measurement and recognition. The impact of adopting ASU 2014-09 is not material to total unrestricted revenues, excess of revenues over expenses or unrestricted net assets.

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 annual reporting periods beginning after December 15, 2017, and interim periods beginning after December 15, 2018. The System is currently evaluating the impact that ASU 2016-14 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

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.

2. Accounting Policies (continued)

Net Patient Service Revenue and Patient Receivables

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others, including retroactive adjustments under payment agreements with third-party payors. The System has agreements with third-party payors that generally provide for payments to the System at amounts different from its established rates. For uninsured patients who do not qualify for charity care, the System recognizes revenue based on established rates, subject to certain discounts as determined by the System. An estimated provision for uncollectible accounts is recorded that results in net patient service revenue being reported at the net amount expected to be received. The System has determined, based on an assessment at the consolidated entity level, that patient service revenue is primarily recorded prior to assessing the patient's ability to pay and as such, the entire provision for uncollectible accounts related to patient service revenue is recorded as a deduction from patient service revenue.

Patient receivables are reduced by an allowance for uncollectible accounts. 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. After satisfaction of amounts due from insurance, the System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System.

The System is paid a prospectively determined rate for the majority of inpatient acute care and outpatient, skilled nursing, and rehabilitation services provided (principally Medicare, Medicaid, and certain insurers). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Payments for capital are received on a prospective basis for Medicare and on a cost reimbursement methodology for Medicaid. Payments are received on a prospective basis for the System's medical education costs, subject to certain limits. The System is paid for cost reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicare Administrative Contractor. Provision for estimated retroactive adjustments, if any, resulting from regulatory matters or other adjustments under payment agreements are estimated in the period the related services are provided. The System recorded an increase in net patient service revenue of $5.9 million and $12.0 million in 2017 and 2016, respectively, related to changes in estimates.

In 2014, the Provider Reimbursement Review Board provided a favorable decision to the System regarding the graduate medical education program for Weston Hospital. The decision requires the Centers for Medicare and Medicaid Services (CMS) to reimburse Weston Hospital on its annual cost reports for graduate medical education under new program regulations, which includes all years since the hospital opened in 2001. The System recorded an increase in net patient service revenue of $7.5 million in 2016 related to changes in estimates.

2. Accounting Policies (continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation as well as significant regulatory action, and, in the normal course of business, the System is subject to contractual reviews and audits, including audits initiated by the Medicare Recovery Audit Contractor program. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term. The System believes it is in compliance with applicable laws and regulations governing the Medicare and Medicaid programs and that adequate provisions have been made for any adjustments that may result from final settlements.

As part of integration efforts involving Akron General Health System (Akron General) and through review of contractual relationships between Akron General and some of its independent physician practice groups, the System 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 Federal Anti-Kickback Statute, Stark Law, False Claims Act and/or other laws and regulations. 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 ultimate amount of the liability at this time.

Charity Care

The System provides care to patients who do not have the ability to pay and who qualify for charity care pursuant to established policies of the System. Charity care is defined as services for which patients have the obligation and willingness to pay but do not have the ability to do so. The System does not report charity care as net patient service revenue. The cost of charity care provided in 2017 and 2016 approximated $91 million and $87 million, respectively. The System estimated these costs by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients.

The System participates in the Hospital Care Assurance Program (HCAP). Ohio created HCAP to financially support those hospitals that service a disproportionate share of low-income patients unable to pay for care. HCAP funds basic, medically necessary hospital services for patients whose family income is at or below the federal poverty level, which includes Medicaid patients and patients without health insurance. The System recorded HCAP expenses of $8.3 million and revenues of $3.1 million for the years ended December 31, 2017 and 2016, respectively, which are included in net patient service revenue.

2. Accounting Policies (continued)

Management Service Agreements

The System has management service agreements with regional, national and international organizations to provide advisory services for various healthcare ventures. The scope of these services range from managing current healthcare operations that are designed to improve clinical quality, innovation, patient care, medical education and research at other healthcare organizations and educational institutions to managing the construction, training, organizational infrastructure, and operational management of healthcare entities. The System recognizes revenues related to management service agreements on a pro rata basis over the term of the agreements as services are provided. Payments received in advance are recorded as deferred revenue until the services have been provided. The System has recorded deferred revenue related to management service agreements, included in other current liabilities, of $15.7 million and $13.6 million at December 31, 2017 and 2016, respectively. Revenue related to management service agreements for 2017 and 2016 was $113.9 million and $99.5 million, respectively, and is included in other unrestricted revenues.

Cash and Cash Equivalents

The System considers all highly liquid investments with original maturities of three months or less when purchased to be cash equivalents. Cash equivalents are recorded at fair value in the consolidated balance sheets and exclude amounts included in long-term investments and investments for current use.

Inventories

Inventories (primarily supplies and pharmaceuticals) are stated at an average cost or the lower of cost (first-in, first-out method) or market and are recorded in other current assets.

Property, Plant, and Equipment

Property, plant, and equipment purchased by the System are recorded at cost. Donated property, plant, and equipment are recorded at fair value at the date of donation. Expenditures that substantially increase the useful lives of existing assets are capitalized. Routine maintenance and repairs are expensed as incurred. Depreciation, including amortization of capital leased assets, is computed by the straight-line method using the estimated useful lives of individual assets. Buildings are assigned useful lives ranging from five years to forty years. Equipment is assigned a useful life ranging from three to twenty years. Interest cost incurred on borrowed funds during the period of construction of capital assets and interest income on unexpended project funds are capitalized as a component of the cost of acquiring those assets. The System records costs and legal obligations associated with long-lived asset retirements. Assets acquired though capital lease arrangements are excluded from the consolidated statements of cash flows.

2. Accounting Policies (continued)

Impairment of Long-Lived Assets

The System evaluates the recoverability of long-lived assets and the related estimated remaining lives when indicators of impairment are present. For purposes of impairment analysis, assets are grouped with other assets and liabilities at the lowest level for which identifiable cash flows are largely independent of the cash flows of other assets and liabilities. The System records an impairment charge or changes the useful life if events or changes in circumstances indicate that the carrying amount may not be recoverable or the useful life has changed.

Investments and Investment Income

Investments in equity securities with readily determinable fair values and all investments in debt securities are recorded at fair value in the consolidated balance sheets. Investments, excluding alternative investments, are primarily classified as trading. Investment transactions are recorded on a settlement date basis. Realized gains and losses are determined using the average cost method.

Commingled investment funds are valued using, as a practical expedient, the net asset value as provided by the respective investment companies and partnerships. There are no significant redemption restrictions on the commingled investment funds.

Investments in alternative investments, which include hedge funds, private equity/venture funds and real estate funds, 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 net asset value information provided by the respective partnership or third-party fund administrators. Investments held by the partnerships consist of marketable securities as well as securities that do not have readily determinable values. The values of the securities held by the limited partnerships that do not have readily determinable values are determined by the general partner and are based on historical cost, appraisals, or other valuation estimates that require varying degrees of judgment. There is inherent uncertainty in such valuations, and the estimated fair values may differ from the values that would have been used had a ready market for the securities existed. Generally, the equity method investment balance of the System's holdings in alternative investments reflects net contributions to the partnerships and the System's share of realized and unrealized investment income and expenses. The investments may individually expose the System to securities lending, short sales, and trading in futures and forward contract options and other derivative products. The System's risk is limited to its carrying value. The financial statements of the limited partnerships are audited annually.

Alternative investments can be divested only at specified times in accordance with terms of the partnership agreements. Hedge fund redemptions typically contain restrictions that allow for a portion of the withdrawal proceeds to be held back from distribution while the underlying investments are liquidated. These redemptions are subject to lock-up provisions that are generally imposed upon initial investment in the fund. Private equity/venture funds and real estate funds are generally closed-end funds and have significant redemption restrictions that prohibit redemptions during the fund's life.

2. Accounting Policies (continued)

Investment return, 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 for self-insurance, which are included in other unrestricted revenues. Donor-restricted investment return on temporarily and permanently restricted investments is included in temporarily restricted net assets.

Certain of the System's assets and liabilities are exposed to various risks, such as interest rate, market, and credit risks.

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.

Authoritative guidance provides an option to elect fair value as an alternative measurement for selected financial assets and liabilities not previously recorded at fair value. The System did not elect fair value accounting for any assets or liabilities that are not currently required to be measured at fair value.

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.

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.

2. Accounting Policies (continued)

Goodwill and Other Intangibles

Goodwill has resulted from business combinations, primarily physician practice acquisitions, and is based on the purchase price in excess of the fair values of assets acquired and liabilities assumed at the acquisition date. Annually, or when indicators of impairment exist, the System evaluates goodwill for impairment to determine whether there are events or circumstances that indicate it is more likely than not that the fair value of a reporting unit is less than its carrying amount. The System considers assets to be impaired and writes them down to fair value if the expected undiscounted cash flows are less than the carrying amounts.

Intangible assets other than goodwill are recorded at fair value in the period of acquisition. Intangible assets with finite lives, which consist primarily of patient medical records, non-compete agreements and leasehold interests, are amortized over their estimated useful lives, ranging from two to five years, with a weighted-average amortization period of approximately three years.

Derivative Instruments

The System's derivative financial instruments consist of interest rate swaps and foreign currency forward contracts (Note 12), which are recognized as assets or liabilities in the consolidated balance sheets at fair value.

The System accounts for changes in the fair value of derivative instruments depending on whether they are designated and qualified as part of a hedging relationship and further, on the type of hedging relationship. The System has not designated any derivative instruments as hedges. Accordingly, the changes in fair value of derivative instruments and the related cash payments are recorded in derivative losses in the consolidated statements of operations and changes in net assets.

Foreign Currency Translation

The statements of operations of foreign subsidiaries whose functional currencies are other than the U.S. dollar are translated into U.S. dollars using average exchange rates for the period. The assets and liabilities of foreign subsidiaries whose functional currencies are other than the U.S. dollar are translated into U.S. dollars using exchange rates as of the balance sheet date. The U.S. dollar effects that arise from translating the net assets of these subsidiaries at changing rates are recorded as foreign currency translation gains and losses in the consolidated statements of operations and changes in net assets. Cumulative foreign currency translation losses included in unrestricted net assets were $42.1 million and $71.4 million at December 31, 2017 and 2016, respectively.

Debt Issuance Costs

Debt issuance costs are amortized over the period the obligation is outstanding using the straight-line method, which approximates the interest method.

2. Accounting Policies (continued)

Contributions

Unconditional donor pledges to give cash, marketable securities, and other assets are reported at fair value at the date the pledge is made to the extent estimated to be collectible by the System. Conditional donor promises to give and indications of intentions to give are not recognized until the condition is satisfied. Pledges received with donor restrictions that limit the use of the donated assets are reported as either temporarily or permanently restricted support. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are transferred to unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as other unrestricted revenues if the purpose relates to operations or reported as a change in unrestricted net assets if the purpose relates to capital.

No amounts have been reflected in the consolidated financial statements for donated services. The System pays for most services requiring specific expertise. However, many individuals volunteer their time and perform a variety of tasks that assist the System with various programs.

Grants

Grant revenue is recognized in the period it is earned based on when the applicable project expenses are incurred and project milestones are achieved. Grant payments received in advance of related project expenses are deferred until the expenditure has been incurred and recorded as deferred revenue and included in other current liabilities. The System recorded research grant revenue, included in other unrestricted revenues, of $195.7 million and $189.2 million in 2017 and 2016, respectively.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are used to differentiate resources, the use of which is restricted by donors or grantors to a specific time period or purpose, from resources on which no restrictions have been placed or that arise from the general operations of the System. Temporarily restricted gifts and bequests are recorded as an addition to temporarily restricted net assets in the period received. Permanently restricted net assets consist of amounts held in perpetuity or for terms designated by donors, including the fair value of several perpetual trusts for which the System is an income beneficiary. Earnings on permanently restricted net assets are recorded as investment income in temporarily restricted net assets and subsequently used in accordance with the donor’s designation. Temporarily and permanently restricted net assets are primarily restricted for research, education, and strategic capital projects.

Excess of Revenues Over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments classified as nontrading, retirement benefits adjustments, foreign currency translation gains and losses, contributions of long-lived assets (including assets acquired using grants or contributions that by donor restriction were to be used for the purpose of acquiring such assets), and transfers of net assets to maintain donor-restricted endowment funds at the level required by donor stipulations or law.

3. Net Patient Service Revenue and Patient Receivables

Net patient service revenue before the provision for uncollectible accounts by major payor source for the years ended December 31, 2017 and 2016, are as follows (in thousands):

	2017		2016	
Medicare	**$ 2,584,950**	**33%**	$ 2,521,242	33%
Medicaid	**646,934**	**8**	572,130	8
Managed care and commercial	**4,400,325**	**57**	4,288,570	57
Self-pay	**162,342**	**2**	169,124	2
	$ 7,794,551	**100%**	$ 7,551,066	100%

The System records an estimated provision for uncollectible accounts in the year of service for self-pay accounts receivable, which includes patient receivables associated with self-pay patients and deductible and copayment balances for which third-party coverage provides for a portion of the services provided. The System's allowance for doubtful accounts was 16% and 15% of accounts receivable at December 31, 2017 and 2016, respectively. Write-offs on self-pay accounts receivable decreased $83.5 million in 2017 compared to 2016. The System does not maintain a material allowance for uncollectible accounts for third-party payors.

The System's concentration of credit risk relating to patient receivables is limited due to the diversity of patients and payors. Patient receivables consist of amounts due from government programs, commercial insurance companies, other group insurance programs, and private pay patients. Patient receivables due from Medicare, Medicaid, and one commercial payor account for approximately 27%, 9%, and 23% at December 31, 2017, and 29%, 8%, and 23% at December 31, 2016, respectively, of the System's total patient receivables. Revenues from the Medicare and Medicaid programs and one commercial payor account for approximately 33%, 8%, and 17% for 2017, and 33%, 8%, and 17% for 2016, respectively, of the System's net patient service revenue. Excluding these payors, no one payor represents more than 10% of the System's patient receivables or net patient service revenue.

4. Cash, Cash Equivalents, and Investments

The composition of cash, cash equivalents, and investments at December 31, 2017 and 2016, is as follows (in thousands):

	2017	2016
Cash and cash equivalents	**$ 770,654**	$ 687,410
Fixed income securities:		
U.S. treasuries	**1,075,486**	963,715
U.S. government agencies	**18,964**	20,270
U.S. corporate	**83,383**	167,025
U.S. government agencies asset-backed securities	**25,139**	25,102
Corporate asset-backed securities	**4,895**	2,829
Foreign	**21,267**	44,759
Fixed income mutual funds	**391,971**	222,670
Commingled fixed income funds	**791,372**	663,154
Common and preferred stocks:		
U.S.	**475,141**	422,947
Foreign	**297,573**	267,061
Equity mutual funds	**262,991**	381,686
Commingled equity funds	**2,029,255**	1,591,389
Commingled commodity funds	**127,690**	122,297
Alternative investments:		
Hedge funds	**1,142,932**	1,134,136
Private equity/venture funds	**854,632**	696,786
Real estate	**483,996**	452,018
Pending purchases of investments	**215,000**	–
Total cash, cash equivalents, and investments	**$ 9,072,341**	$ 7,865,254

Pending purchases of investments of $215.0 million at December 31, 2017 were invested as hedge funds on January 1, 2018.

Investments are primarily maintained in a master trust fund administered using a bank as trustee. The management of the majority of the System's investments is conducted by numerous external investment management organizations that are monitored by the System. There were 138 investment managers at December 31, 2017 focusing on various investment strategies, including equity investments, fixed income investments, commodities and alternative investments. The alternative investments have separate administrators and custodian arrangements. Alternative investments also include five holdings in which the System invests directly.

4. Cash, Cash Equivalents, and Investments (continued)

Total investment return is comprised of the following for the years ended December 31, 2017 and 2016 (in thousands):

	2017	2016
Other unrestricted revenues:		
Interest income and dividends	**$ 2,909**	$ 2,750
Nonoperating gains, net:		
Interest income and dividends	**70,135**	61,430
Net realized gains on sales of investments	**177,901**	157,358
Net change in unrealized gains on investments	**518,861**	100,079
Equity method income on alternative investments	**152,178**	104,184
Investment management fees	**(22,936)**	(18,860)
	896,139	404,191
Other changes in net assets:		
Investment income on restricted investments and other	**54,250**	24,771
Total investment return	**$ 953,298**	$ 431,712

5. Other Current Assets and Liabilities and Other Noncurrent Assets and Liabilities

Other current and noncurrent assets at December 31, 2017 and 2016, consist of the following (in thousands):

	2017	2016
Current:		
Inventories	**$ 143,437**	$ 133,074
Prepaid expenses	**57,010**	52,989
Pledges receivable, current *(Note 9)*	**45,657**	58,188
Research receivables	**36,143**	36,390
Estimated amounts due from third-party payors	**9,397**	41,162
Other	**83,082**	75,089
Total other current assets	**$ 374,726**	$ 396,892

	2017	2016
Noncurrent:		
Deferred compensation plan assets	**$ 206,085**	$ 162,820
Goodwill and other intangible assets	**101,999**	92,574
Note receivable	**37,204**	37,455
Investments in affiliates	**33,921**	37,244
Other	**95,801**	79,914
Total other noncurrent assets	**$ 475,010**	$ 410,007

5. Other Current Assets and Liabilities and Other Noncurrent Assets and Liabilities (continued)

Other current and noncurrent liabilities at December 31, 2017 and 2016 consist of the following (in thousands):

	2017	2016
Current:		
Research deferred revenue	**$ 67,492**	$ 71,885
Interest payable	**52,236**	64,141
Current portion of professional and general liability insurance reserves *(Note 13)*	**51,051**	52,125
Estimated amounts due to third-party payors	**40,053**	45,000
Management contracts and other deferred revenue	**38,026**	38,602
Employee benefit related liabilities	**29,211**	34,384
Current portion of pledges payable	**15,460**	306
Foreign currency forward contracts *(Note 12)*	**–**	11,076
Other	**145,133**	145,042
Total other current liabilities	**$ 438,662**	$ 462,561

	2017	2016
Noncurrent:		
Employee benefit related liabilities	**$ 256,797**	$ 216,666
Interest rate swap liabilities *(Note 12)*	**123,989**	139,422
Pledge liabilities	**20,328**	34,134
Estimated amounts due to third-party payors	**18,665**	24,523
Gift annuity liabilities	**12,120**	11,114
Accrued income tax liabilities *(Note 15)*	**606**	2,258
Other	**135,061**	62,428
Total other noncurrent liabilities	**$ 567,566**	$ 490,545

6. Goodwill and Other Intangible Assets

The System recorded goodwill of $10.9 million and $4.1 million in 2017 and 2016, respectively, related to the acquisitions of various physician practices. Goodwill is recorded in other noncurrent assets in the consolidated balance sheets.

6. Goodwill and Other Intangible Assets (continued)

The changes in the carrying amount of goodwill for the years ended December 31, 2017 and 2016 are as follows (in thousands):

	Year Ended December 31	
	2017	**2016**
Balance, beginning of year	**$ 58,497**	$ 54,411
Goodwill acquired	**10,923**	4,086
Balance, end of year	**$ 69,420**	$ 58,497

The System acquired other intangible assets of $0.2 million and $0.4 million in 2017 and 2016, respectively, related to the acquisitions of various physician practices. Other intangible assets are recorded in other noncurrent assets in the consolidated balance sheets.

Other intangible assets at December 31, 2017 and 2016 consist of the following (in thousands):

	2017		**2016**	
	Historical Cost	**Accumulated Amortization**	**Historical Cost**	**Accumulated Amortization**
Trade name	**$ 31,700**	**$ –**	$ 31,700	$ –
Finite-lived intangible assets	**6,261**	**5,382**	6,643	4,266
Total	**$ 37,961**	**$ 5,382**	$ 38,343	$ 4,266

Amortization related to finite-lived intangible assets was $1.7 million and $2.3 million in 2017 and 2016, respectively, and is included in depreciation and amortization in the consolidated statements of operations and changes in net assets. Future amortization is as follows (in thousands): 2018 – $602; 2019 – $219; and 2020 – $58.

7. Fair Value Measurements

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

December 31, 2017	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	**$ 770,609**	**$ 45**	**$ –**	**$ 770,654**
Fixed income securities:				
U.S. treasuries	**1,075,486**	**–**	**–**	**1,075,486**
U.S. government agencies	**–**	**18,964**	**–**	**18,964**
U.S. corporate	**–**	**83,383**	**–**	**83,383**
U.S. government agencies asset-backed securities	**–**	**25,139**	**–**	**25,139**
Corporate asset-backed securities	**–**	**4,895**	**–**	**4,895**
Foreign	**–**	**21,267**	**–**	**21,267**
Fixed income mutual funds	**391,971**	**–**	**–**	**391,971**
Common and preferred stocks:				
U.S.	**473,420**	**1,721**	**–**	**475,141**
Foreign	**296,025**	**1,548**	**–**	**297,573**
Equity mutual funds	**262,991**	**–**	**–**	**262,991**
Total cash and investments	**3,270,502**	**156,962**	**–**	**3,427,464**
Perpetual and charitable trusts	**–**	**53,728**	**–**	**53,728**
Total assets at fair value	**$ 3,270,502**	**$ 210,690**	**$ –**	**$ 3,481,192**
Liabilities				
Interest rate swaps	**$ –**	**$ 123,989**	**$ –**	**$ 123,989**
Total liabilities at fair value	**$ –**	**$ 123,989**	**$ –**	**$ 123,989**

7. 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

7. Fair Value Measurements (continued)

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

	2017	2016
Cash, cash equivalents, and investments measured at fair value	**$ 3,427,464**	$ 3,205,474
Commingled funds measured at net asset value	**2,948,317**	2,376,840
Alternative investments accounted for under the equity method	**2,481,560**	2,282,940
Pending purchases of investments	**215,000**	–
Total cash, cash equivalents, and investments	**$ 9,072,341**	$ 7,865,254
Perpetual and charitable trusts measured at fair value	**$ 53,728**	$ 45,350
Interests in foundations	**26,915**	21,869
Trusts and interests in foundations	**$ 80,643**	$ 67,219

Interest rate swaps and forward currency forward contracts (Note 12) are reported in other current and 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 2.5% 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.

7. 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.

8. Property, Plant, and Equipment

Property, plant, and equipment at December 31, 2017 and 2016 consist of the following (in thousands):

	2017	2016
Land and improvements	**$ 406,463**	$ 390,669
Buildings	**5,657,283**	5,350,756
Leasehold improvements	**30,832**	30,609
Equipment	**1,671,465**	1,599,562
Computer hardware and software	**855,524**	797,300
Construction-in-progress	**754,564**	611,587
Leased facilities and equipment	**158,785**	150,561
	9,534,916	8,931,044
Accumulated depreciation and amortization	**(4,835,219)**	(4,418,966)
	$ 4,699,697	$ 4,512,078

Included in the preceding table is unamortized computer software of $193.2 million and $188.3 million at December 31, 2017 and 2016, respectively. Amortization of computer software totaled $47.9 million and $48.9 million in 2017 and 2016, respectively. Amortization of computer software for the five years subsequent to December 31, 2017, is as follows (in millions): 2018 – $42.8; 2019 – $33.8; 2020 – $25.5; 2021 – $22.5; and 2022 – $21.1.

Accumulated amortization of leased facilities and equipment was $70.4 million and $58.8 million at December 31, 2017 and 2016, respectively.

9. Pledges Receivable

Outstanding pledges receivable from various corporations, foundations, and individuals at December 31, 2017 and 2016, are as follows (in thousands):

	2017	2016
Pledges due:		
In less than one year	**$ 61,439**	$ 72,117
In one to five years	**115,638**	108,075
In more than five years	**81,429**	88,540
	258,506	268,732
Allowance for uncollectible pledges and discounting	**(61,830)**	(59,835)
Current portion (net of allowance for uncollectible pledges of $15.6 million in 2017 and $13.9 million in 2016)	**(45,657)**	(58,188)
	$ 151,019	$ 150,709

10. Notes Payable and Capital Leases

Notes payable and capital leases at December 31, 2017 and 2016 consist of the following (in thousands):

	2017	2016
Notes payable with interest rates up to 5.0%	**$ 376,521**	$ 381,308
Revolving credit facility	**60,000**	60,000
Capital leases for facilities and equipment	**93,986**	96,435
City of Lakewood lease	**513**	1,565
	531,020	539,308
Unamortized debt issuance costs	**(387)**	(620)
Less current portion	**(395,793)**	(21,969)
Total notes payable and capital leases	**$ 134,840**	$ 516,719

In 2015, the System executed a $375.0 million term loan agreement with a financial institution. 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) plus an applicable spread. The interest rate on the term loan ranged from 1.11% to 1.85% in 2017 (average rate 1.59%) and from 0.73% to 1.11% in 2016 (average rate 0.99%).

10. Notes Payable and Capital Leases (continued)

In 2016, the System entered into a $300 million revolving credit facility with multiple financial institutions. The revolving credit facility expires in 2019 with provisions allowing the System 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. At December 31, 2017, the System has the intent and the ability to refinance the short-term loans beyond one year. The revolving credit facility bears interest at a variable rate based on the London Interbank Offered Rate (LIBOR) plus an applicable spread. Amounts outstanding on the revolving credit facility as of December 31, 2017 and 2016 totaled $60.0 million. The proceeds were used to pay the full outstanding amount on a line of credit executed in January 2016 and terminated in September 2016. The interest rate on the revolving credit facility ranged from 1.52% to 2.09% in 2017 (average rate 1.70%) and from 1.38% to 1.53% in 2016 (average rate 1.40%).

Maturities of the notes payable and revolving credit facility for the five years subsequent to December 31, 2017, are as follows (in thousands): 2018 – $376,495; 2019 – $60,026; 2020 – $0; 2021 – $0; and 2022 – $0.

Future minimum capital lease payments, including total interest of $18.5 million, are as follows (in thousands): 2018 – $23,128; 2019 – $22,819; 2020 – $16,102; 2021 – $12,189; and 2022 – $10,071; and thereafter – $28,193. Assets acquired through capital lease arrangements are included in property, plant, and equipment.

The City of Lakewood, Ohio (the City) leases real and personal property to Lakewood Hospital Association (LHA) for the purpose of enabling the operation of certain healthcare services at Lakewood Hospital. In connection with executing an Amended Lease with the City, LHA had agreed to make additional payments to the City. In 2015, the Amended Lease was further amended to shorten the lease term and to reduce the total payments due under the lease. The payments under the current lease as amended range in annual amounts up to $1.2 million through 2018, or until certain provisions in the lease are satisfied. The net present value of the additional payments discounted at an interest rate of 6% is $0.5 million and $1.6 million at December 31, 2017 and 2016, respectively. LHA has approximately $29 million of net assets, included in the System's unrestricted net assets at December 31, 2016, available for use under the terms of the current lease but unavailable to other members of the System.

11. Bonds

Bonds at December 31, 2017 and 2016 consist of the following (in thousands):

	Interest Rate(s)	Final Maturity	Amount Outstanding at December 31 2017	2016
Series 2017A	0.83% to 3.48%	2043	**$ 818,775**	$ –
Series 2017B	1.56% to 3.70%	2043	**169,255**	–
Series 2017C	2.24%	2032	**9,305**	–
Series 2016, Private Placement	3.35%	2046	**325,000**	325,000
Series 2016, Term Loan	Variable rate	2026	**16,270**	17,370
Series 2014	4.86%	2114	**400,000**	400,000
Series 2014A CP Notes	Variable rate	2044	**70,955**	70,955
Series 2013A	3.62% to 4.04%	2042	**73,150**	73,150
Series 2013B	Variable rate	2039	**201,160**	201,160
Series 2013, Keep Memory Alive	Variable rate	2037	**61,165**	63,135
Series 2012A	1.54% to 4.07%	2039	**451,135**	460,080
Series 2011A	2.79% to 4.83%	2032	**160,605**	172,030
Series 2011B	2.94%	2031	**27,785**	29,120
Series 2011C	3.40% to 4.72%	2032	**157,945**	170,995
Series 2009A	5.58%	2039	**–**	305,400
Series 2009B	3.99% to 4.21%	2039	**31,640**	366,215
Series 2008A	4.39%	2043	**7,930**	409,740
Series 2008B	Variable rate	2043	**327,575**	369,250
Series 2003C	Variable rate	2035	**41,905**	41,905
Series 2002	Variable rate	2032	**–**	9,635
			3,351,555	3,485,140
Net unamortized premium			**167,451**	51,287
Unamortized debt issuance costs			**(22,278)**	(22,593)
Current portion			**(62,020)**	(59,770)
Long-term variable rate debt classified as current			**(573,270)**	(527,115)
			$2,861,438	$2,926,949

11. Bonds (continued)

The majority of the System's outstanding revenue bonds are limited obligations of various issuing authorities payable solely by the System pursuant to loan agreements between the borrowing entities and the issuing authorities. Under various financing agreements, the System must meet certain operating and financial performance covenants. The Series 2016 private placement, the Series 2016 term loan and the Series 2014 bonds are issued directly by the Foundation. The Series 2013 Keep Memory Alive bonds are issued directly by Keep Memory Alive, a non-obligated affiliate of the System.

In August 2017, pursuant to certain agreements between the System and the State of Ohio (State) acting by and through the Ohio Higher Education Facility Commission, the State issued $818.8 million of fixed-rate Hospital Refunding Revenue Bonds (Series 2017A Bonds) and $169.3 million of fixed-rate Taxable Hospital Refunding Revenue Bonds (Series 2017B Bonds) for the benefit of the System. Proceeds from the sale of the Series 2017A Bonds and Series 2017B Bonds were used to refund all or a portion of the outstanding Series 2008A, 2008B, 2009A, 2009B and 2012A Bonds and to pay the cost of issuance. The System recorded a loss on extinguishment of debt of $46.2 million related to this transaction, which is recorded in other nonoperating gains and losses in the consolidated statements of operations and changes in net assets.

In December 2017, pursuant to certain agreements between the System and the State of Ohio (State) acting by and through the Ohio Higher Education Facility Commission, the State issued $9.3 million of Hospital Refunding Revenue Bonds (Series 2017C Bonds) for the benefit of the System. Proceeds from the sale of the Series 2017C Bonds were used to refund all of the outstanding Series 2002 Bonds. The Series 2017C Bonds were purchased by a financial institution and are scheduled to be tendered to the System on December 1, 2027. During this term, the bonds bear interest at 2.24% plus an applicable credit spread. The tender date may be extended subject to the consent of the financial institution.

In January 2016, the System entered into a line of credit with a financial institution totaling $60.0 million. The System drew the full amount on the line of credit and also issued $100.0 million of Taxable Hospital Revenue Commercial Paper Notes (Series 2014A CP Notes). The proceeds from the draw on the line of credit and a portion of the proceeds from the issuance of the Series 2014A CP Notes were used to defease the Series 2012 Akron Bonds and redeem the Series 2012 taxable Akron Bonds, the Series 2014A Akron Bonds and the Series 2014B Akron Bonds. The System recorded a loss on extinguishment of debt of $3.9 million in 2016 related to this transaction, which is recorded in other nonoperating gains and losses in the consolidated statements of operations and changes in net assets.

The Series 2014A CP Notes may be issued from time to time in a maximum outstanding face amount of $100 million. At December 31, 2017 and 2016, the System has $71.0 million of outstanding Series 2014A CP Notes.

In August 2016, the System issued private placement debt totaling $325.0 million that was purchased by a financial institution. The private placement debt matures in 2046 and bears interest at a fixed rate of 3.35%. The proceeds of the private placement debt were used for the general corporate purposes of the Foundation.

11. Bonds (continued)

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

Certain of the System's current outstanding bonds bear interest at a variable rate. During 2017 and 2016, the rates for the System's variable rate bonds ranged from 0.47% to 2.18% (average rate 0.91%) and 0.01% to 1.78% (average rate 0.45%), respectively.

Certain variable rate revenue bonds are secured by irrevocable direct pay letters of credit and standby bond purchase agreements totaling $354.2 million at December 31, 2017. Bonds are classified as current in the consolidated balance sheets if they are supported by lines 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 System provides self-liquidity on the Series 2003C Bonds, certain sub-series of the Series 2008B Bonds and the Series 2014A CP Notes. These bonds are classified as current liabilities in the consolidated balance sheets.

During the term of agreements with the issuing authorities, the System is required to make specified deposits with trustees to fund principal and interest payments when due. Also, unexpended bond proceeds are held by the trustee and released to the System for approved requisition requests for capital projects. There were no unexpended bond proceeds at December 31, 2017 and 2016. The current portion of the funds held by trustees, which consists of deposits with the trustees to fund current principal and interest payments, was $103.9 million at December 31, 2017 and is included in investments for current use. There was no current portion of funds held by trustees at December 31, 2016.

The System is subject to certain restrictive covenants, including provisions relating to certain debt ratios, days cash on hand, and other matters. The System was in compliance with these covenants at December 31, 2017 and 2016.

Combined current aggregate scheduled maturities, assuming the remarketing of the variable rate demand bonds, for the five years subsequent to December 31, 2017, are as follows (in thousands): 2018 – $62,020; 2019 – $64,035; 2020 – $66,020; 2021 – $68,870; and 2022 – $71,825.

Total interest paid approximated $153.4 million and $134.4 million in 2017 and 2016, respectively. Capitalized interest cost approximated $0.6 million and $1.1 million in 2017 and 2016, respectively.

12. Derivative Instruments

The System has entered into various derivative financial instruments to manage interest rate risk and foreign currency exposures.

12. Derivative Instruments (continued)

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 $615.0 million and $633.1 million at December 31, 2017 and 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.

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

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at December 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	**59,075**	60,825
Fixed	2030	5.06%	100% of LIBOR	**59,050**	60,800
Fixed	2031	3.04%	68% of LIBOR	**49,850**	52,625
Fixed	2032	4.32%	79% of LIBOR	**2,279**	2,361
Fixed	2032	4.33%	70% of LIBOR	**4,557**	4,723
Fixed	2032	3.78%	70% of LIBOR	**2,279**	2,361
Fixed	2036	4.90%	100% of LIBOR	**49,700**	49,725
Fixed	2036	4.90%	100% of LIBOR	**76,950**	78,350
Fixed	2037	4.62%	100% of SIFMA	**61,165**	63,135
				$ 614,988	$ 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.

12. Derivative Instruments (continued)

In June 2016, the System entered into five foreign currency contracts, expiring between September 2016 and September 2017, with a total outstanding notional amount of $150 million. At December 31, 2017, the System has no outstanding foreign currency forward contracts. At December 31, 2016, the System had three outstanding foreign currency forward contracts with a total notional amount of $75 million. The foreign currency contracts are not designated as hedging instruments.

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

	Derivatives Liability			
	December 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	**$ 123,989**	Other noncurrent liabilities	$ 139,422
Foreign currency contracts		**$ –**	Other current liabilities	$ 11,076

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

	Location of Loss Recognized	Year Ended December 31 2017	2016
Derivatives not designated as hedging instruments			
Interest rate swap agreements	Derivative losses	**$ (5,309)**	$ (4,539)
Foreign currency contracts	Derivative gains (losses)	**$ 3,004**	$ (18,285)

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 December 31, 2017 and 2016, the System posted $69.2 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.

13. Professional and General Liability Insurance

The System manages its professional and general liability insurance program through a captive insurance arrangement.

In the ordinary course of business, professional and general liability claims have been asserted against the System by various claimants. These claims are in various stages of processing or, in certain instances, are in litigation. In addition, there are known incidents, and there also may be unknown incidents, which may result in the assertion of additional claims. The System has accrued its best estimate of both asserted and unasserted claims based on actuarially determined amounts. These estimates are subject to the effects of trends in loss severity and frequency, and ultimate settlement of professional and general liability claims may vary significantly from the estimated amounts.

The System's professional and general liability insurance reserves of $198.4 million and $198.2 million at December 31, 2017 and 2016, respectively, are recorded as current and noncurrent liabilities and include discounted estimates of the ultimate costs for both asserted claims and unasserted claims. Asserted claims for the System's reserves were discounted at 2.25% and 1.75% at December 31, 2017 and 2016, respectively. Unasserted claims were discounted at 2.50% and 2.25% at December 31, 2017 and 2016, respectively. Through the captive insurance subsidiary, the System has set aside investments of $210.9 million ($51.1 million included in investments for current use) and $180.3 million ($52.1 million included in investments for current use) at December 31, 2017 and 2016, respectively, of which $37.6 million and $37.0 million at December 31, 2017 and 2016, respectively, are restricted in accordance with reinsurance trust agreements related to coverage of the Florida operations and other reinsurance programs provided by the captive insurance subsidiary.

Activity in the professional and general liability insurance reserves is summarized as follows (in thousands):

	2017	2016
Balance at beginning of year	**$ 198,234**	$ 191,840
Incurred related to:		
Current period	**65,901**	65,512
Prior period	**(14,288)**	(13,985)
Total incurred	**51,613**	51,527
Paid related to:		
Current period	**5,219**	6,862
Prior period	**44,828**	37,710
Total paid	**50,047**	44,572
	1,566	6,955
(Decrease) increase in unasserted claims	**(1,414)**	1,671
Decrease in reinsurance recoverable	**(8)**	(2,232)
Balance at end of year	**$ 198,378**	$ 198,234

13. Professional and General Liability Insurance (continued)

The foregoing reconciliation shows $14.3 million and $14.0 million of favorable development in 2017 and 2016, respectively, due to changes in actuarial estimates as a result of lower claim activity, closed claims, and expedited settlement of claims, which has reduced claim expenses and resulted in more favorable settlements. The System utilizes a combination of actual and industry statistics to estimate loss and loss adjustment expense reserves.

14. Pensions and Other Postretirement Benefits

The System maintains four defined benefit pension plans, including two plans related to Akron General. The CCHS Retirement Plan is a tax-qualified defined benefit pension plan that provides benefits to substantially all employees of the System, except those employed by Akron General. All benefit accruals under the CCHS Retirement Plan ceased as of December 31, 2012. Akron General has a tax-qualified defined benefit plan covering substantially all of its employees that were hired before 2004 who meet certain eligibility requirements. In 2009, Akron General ceased benefit accruals for substantially all nonunion employees, with benefit accruals for remaining employees ceasing at various intervals through December 31, 2017. The benefits for the System's tax-qualified defined benefit pension plans are provided based on age, years of service, and compensation. The System's policy for its tax-qualified 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 unfunded, nonqualified defined benefit supplemental retirement plans, which cover certain professional staff and administrative employees.

The System sponsors two noncontributory, defined contribution plans, and three contributory, defined contribution plans. The Cleveland Clinic Investment Pension Plan (IPP) is a noncontributory, defined contribution plan, which covers substantially all of the System's employees, except employees covered by the Cleveland Clinic Cash Balance Plan and those employed by Akron General. The System's contribution to the IPP for participants is based upon a percentage of employee compensation that is based on years of service. The Cleveland Clinic Cash Balance Plan (CBP) is a noncontributory, defined contribution plan that covers certain professional and administrative employees not covered by the IPP. The System's contribution to the CBP is a percentage of employee compensation that is determined according to age. The System also sponsors three tax-qualified contributory, defined contribution plans, including two plans related to Akron General, which cover substantially all employees. The plans permit employees to make pre-tax employee deferrals and to become entitled to certain employer matching contributions that are based on employee contributions.

The System provides healthcare benefits upon retirement for substantially all of its employees who meet certain minimum age and years of service provisions at retirement. The System's healthcare plans generally provide for cost sharing, in the form of retiree contributions, deductibles, and coinsurance. The System's policy is to fund the annual cost of healthcare benefits from the general assets of the System. The estimated cost of these postretirement benefits is actuarially determined and accrued over the employees' service periods.

14. Pensions and Other Postretirement Benefits (continued)

The mortality tables used to calculate the defined benefit obligation for the System's defined benefit and postretirement health benefit plans are based on the RP-2014 "Employees" table unadjusted, with generational projection for non-annuitants and the RP-2014 "Healthy Annuitants" table unadjusted, with generational projection for annuitants. In 2016, the System updated the generational mortality projections scale from Scale MP-2015 to Scale MP-2016. In 2017, the System updated the generational mortality projections scale from Scale MP-2016 to Scale MP-2017. The System believes that the updated mortality rates are the best estimate of future experience.

The System expects to make contributions of $8.9 million to the defined benefit pension plans in 2018. Pension benefit payments over the next ten years are estimated as follows: 2018 – $112.6 million; 2019 – $116.1 million; 2020 – $116.6 million; 2021 – $120.5 million; 2022 – $117.4 million; and in the aggregate for the five years thereafter – $560.1 million.

The System expects to make contributions of $4.1 million to other postretirement benefit plans in 2018. Other postretirement benefit payments over the next ten years, net of the average annual Medicare Part D subsidy of approximately $2.3 million, are estimated as follows: 2018 –$4.1 million; 2019 – $4.0 million; 2020 – $3.9 million; 2021 – $3.7 million; 2022 – $3.4 million; and in the aggregate for the five years thereafter – $11.9 million.

No plan assets are expected to be returned to the employer during 2018.

The System is required to recognize the funded status, which is the difference between the fair value of plan assets and the projected benefit obligations, of its pension and other postretirement benefit plans in the consolidated balance sheets, with a corresponding adjustment to unrestricted net assets. Amounts recorded in unrestricted net assets consist of actuarial gains and losses and prior service credits and costs. Actuarial gains and losses recorded in unrestricted net assets outside of the corridor, which is 10% of the greater of the projected benefit obligation or the fair value of the plan assets, will be recognized as a component of net periodic benefit cost immediately in the current period. Prior service credits and costs will be amortized over future periods, pursuant to the System's accounting policy.

Unrecognized prior service credits and costs are amortized on a straight-line basis over the estimated life of the plan participants. In 2018, the System is expected to amortize $2.9 million of unrecognized prior service credits in net periodic benefit costs.

14. Pensions and Other Postretirement Benefits (continued)

Included in unrestricted net assets at December 31, 2017 and 2016 are the following amounts that have not yet been recognized in net periodic benefit cost (in thousands):

	Defined Benefit Pension Plans		Other Postretirement Benefits	
	2017	**2016**	**2017**	**2016**
Unrecognized actuarial losses (gains)	**$ 173,279**	$ 168,337	**$ (9,553)**	$ (9,890)
Unrecognized prior service credit	**(15,621)**	(12,763)	**(7,994)**	(8,946)
Total	**$ 157,658**	$ 155,574	**$ (17,547)**	$ (18,836)

Unrecognized actuarial losses (gains) included in unrestricted net assets represent amounts within the corridor that do not require recognition in net periodic benefit cost for each respective year.

Changes in plan assets and benefit obligations recognized in unrestricted net assets for the years ended December 31, 2017 and 2016 are as follows (in thousands):

	Defined Benefit Pension Plans		Other Postretirement Benefits	
	2017	**2016**	**2017**	**2016**
Current year actuarial (loss) gain	**$ (45,990)**	$ (130,527)	**$ 5,674**	$ 6,482
Recognition of actuarial loss (gain) in excess of corridor	**41,048**	108,526	**(6,011)**	(4,407)
Current year prior service credit	**4,538**	–	–	4,355
Amortization of prior service credit	**(1,680)**	(1,681)	**(952)**	(537)
Total	**$ (2,084)**	$ (23,682)	**$ (1,289)**	$ 5,893

14. Pensions and Other Postretirement Benefits (continued)

The following table sets forth the funded status of the System's pensions and other postretirement benefit plans and the amounts recognized in the System's December 31, 2017 and 2016 consolidated balance sheets (in thousands):

	Defined Benefit Pension Plans		Other Postretirement Benefits	
	2017	**2016**	**2017**	**2016**
Change in projected benefit obligation:				
Projected benefit obligation at beginning of year	**$1,736,681**	$1,649,131	**$ 98,900**	$ 111,309
Service cost	**196**	2,178	**1,313**	1,681
Interest cost	**71,493**	76,074	**4,273**	5,368
Actuarial loss (gain)	**89,403**	98,362	**(5,674)**	(6,482)
Participant contributions	**–**	**–**	**13,437**	12,186
Plan amendments	**(4,538)**	**–**	**–**	(4,357)
Curtailment	**(62)**	**–**	**–**	**–**
Settlement payments	**(68,248)**	**–**	**–**	**–**
Benefits paid	**(39,482)**	(89,064)	**(17,606)**	(21,928)
Federal subsidy	**–**	**–**	**890**	1,123
Projected benefit obligation at end of year	**1,785,443**	1,736,681	**95,533**	98,900
Change in plan assets:				
Fair value of plan assets at beginning of year	**1,342,970**	1,255,431	**–**	**–**
Actual return on plan assets	**128,022**	47,291	**–**	**–**
Participant contributions	**–**	**–**	**13,437**	12,186
System contributions	**11,897**	129,312	**4,169**	9,742
Benefits paid	**(107,730)**	(89,064)	**(17,606)**	(21,928)
Fair value of plan assets at end of year	**1,375,159**	1,342,970	**–**	**–**
Accrued retirement benefits	**$ (410,284)**	$ (393,711)	**$ (95,533)**	$ (98,900)
Current liabilities	**$ (8,882)**	$ (9,263)	**$ (4,102)**	$ (4,474)
Noncurrent liabilities	**(401,402)**	(384,448)	**(91,431)**	(94,426)
Net liability recognized in consolidated balance sheets	**$ (410,284)**	$ (393,711)	**$ (95,533)**	$ (98,900)

The accumulated benefit obligation for all defined benefit pension plans was $1.8 billion and $1.7 billion at December 31, 2017 and 2016, respectively.

14. Pensions and Other Postretirement Benefits (continued)

The CCHS Retirement Plan paid $68.2 million in lump-sum payments in accordance with plan terms in 2017, which exceeded the sum of the service cost and interest cost components of net periodic benefit cost for the year. As a result, the System recorded a settlement charge of $7.6 million for the year ended December 31, 2017. There were no settlement charges for the year ended December 31, 2016.

In 2017, the System amended the Akron General primary defined benefit pension plan to offer a lump sum option to all non-bargained active and terminated vested participants, effective January 1, 2018. As a result of this amendment, the projected benefit obligation decreased $4.5 million in 2017.

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

	Defined Benefit Pension Plans		Other Postretirement Benefits	
	2017	**2016**	**2017**	**2016**
Components of net periodic benefit cost:				
Service cost	**$ 196**	$ 2,178	**$ 1,313**	$ 1,681
Interest cost	**71,493**	76,074	**4,273**	5,368
Expected return on plan assets	**(84,670)**	(79,456)	–	–
Recognition of actuarial loss (gain) in excess of corridor	**33,471**	108,526	**(6,011)**	(4,407)
Settlement charge	**7,577**	–	–	–
Amortization of unrecognized prior service credit	**(1,680)**	(1,681)	**(952)**	(537)
Net periodic benefit cost (credit)	**26,387**	105,641	**(1,377)**	2,105
Defined contribution plans	**224,769**	217,941	–	–
Total	**$ 251,156**	$ 323,582	**$ (1,377)**	$ 2,105

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

14. Pensions and Other Postretirement Benefits (continued)

Weighted-average assumptions used to determine pension and postretirement benefit obligations and net periodic benefit cost are as follows:

	Defined Benefit Pension Plans		Other Postretirement Benefits	
	2017	**2016**	**2017**	**2016**
Weighted-average assumptions:				
Discount rates:				
Used for benefit obligations	**3.74%**	4.24%	**3.83%**	4.36%
Used for net periodic benefit cost	**4.24%**	4.74%	**4.36%**	4.86%
Expected rate of return on plan assets	**6.53%**	6.56%	–	–
Rate of compensation increase:				
Used for benefit obligations	**2.25%**	2.25%	–	–
Used for net periodic benefit cost	**2.25%**	2.25%	–	–

The System uses a direct cost approach to estimate its postretirement benefit obligation for healthcare services provided by the System (internally provided services). Healthcare services provided by non-System entities (externally provided services) are based on the System's historical cost experience.

The annual assumed healthcare cost trend rates for the next year and the assumed trend thereafter is as follows:

	2017	**2016**
Internally provided services:		
Initial rate	**6.00%**	5.50%
Ultimate rate	**4.50%**	4.50%
Year ultimate reached	**2024**	2021
Externally provided services:		
Initial rate	**7.00%**	6.50%
Ultimate rate	**5.50%**	5.50%
Year ultimate reached	**2024**	2021

A one-percentage-point increase or decrease in the healthcare cost trend rate would have increased or decreased service and interest costs in 2017 by $2.4 million and $1.4 million, respectively, and service and interest costs in 2016 by $2.5 million and $1.7 million, respectively.

14. Pensions and Other Postretirement Benefits (continued)

The System's weighted-average asset allocation of pension plan assets at December 31, 2017 and 2016, by asset category, are as follows:

	Percentage of Plan Assets		
	2017	2016	Target Allocation
Asset category			
Interest-bearing cash	**6.4%**	7.0%	0%–10%
Fixed income securities	**45.8**	47.0	40%–80%
Common and preferred stocks	**31.1**	31.1	17%–37%
Alternative investments	**16.7**	14.9	3%–23%
Total	**100.0%**	100.0%	

The System's investment strategy for its pension assets balances the liquidity needs of the pension plans with the long-term return goals necessary to satisfy future pension obligations. The target allocation ranges of the investment pool to various asset classes are designed to diversify the portfolio in a way that achieves an efficient trade-off between long-term return and risk while providing adequate liquidity to meet near-term expenses and obligations.

The System's weighted-average pension portfolio return assumption of 6.53% and 6.56% in 2017 and 2016, respectively, is based on the targeted assumed rate of return through its asset mix at the beginning of each year, which is designed to mitigate short-term return volatility and achieve an efficient trade-off between return and risk. Expected returns and risk for each asset class are formed using a global capital asset pricing model framework in which the expected return is the compensation earned from taking risk. Forward-looking adjustments are made to expected return, volatility, and correlation estimates as well. Additionally, constraints such as permissible asset classes, portfolio guidelines, and liquidity considerations are included in the model.

In 2015, the System updated its investment strategy and modified the target allocations of pension plan assets in the CCHS Retirement Plan based on the current funded status of the plan. Coincident with this update, 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 pension 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 pension plan over time. Additional revisions in asset allocations and expected rate of return on plan assets may occur based on future changes in the funded status of the pension plans.

14. Pensions and Other Postretirement Benefits (continued)

The following tables present the financial instruments in the System's defined benefit pension plans measured at fair value on a recurring basis as of December 31, 2017 and 2016, based on the valuation hierarchy (in thousands):

December 31, 2017	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	**$ 87,571**	**$ 5**	**$ –**	**$ 87,576**
Fixed income securities:				
U.S. treasuries	**360,138**	**–**	**–**	**360,138**
U.S. government agencies	**–**	**5,045**	**–**	**5,045**
U.S. corporate	**–**	**62,672**	**–**	**62,672**
Foreign	**–**	**7,513**	**–**	**7,513**
Fixed income mutual funds	**73,016**	**–**	**–**	**73,016**
Common and preferred stocks:				
U.S.	**69,804**	**–**	**–**	**69,804**
Foreign	**20,342**	**654**	**–**	**20,996**
Equity mutual funds	**92,189**	**–**	**–**	**92,189**
Total assets at fair value	**$ 703,060**	**$ 75,889**	**$ –**	**$ 778,949**

December 31, 2016	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	$ 94,013	$ 2	$ –	$ 94,015
Fixed income securities:				
U.S. treasuries	303,857	–	–	303,857
U.S. government agencies	–	4,431	–	4,431
U.S. corporate	–	83,201	–	83,201
Foreign	–	12,280	–	12,280
Fixed income mutual funds	77,615	–	–	77,615
Common and preferred stocks:				
U.S.	70,524	421	–	70,945
Foreign	27,406	719	–	28,125
Equity mutual funds	78,630	–	–	78,630
Total assets at fair value	$ 652,045	$ 101,054	$ –	$ 753,099

14. Pensions and Other Postretirement Benefits (continued)

Total plan assets in the System's defined benefit pension plans at December 31, 2017 and 2016 are comprised of the following (in thousands):

	2017	2016
Plan assets measured at fair value	**$ 778,949**	$ 753,099
Commingled fixed-income funds measured at net asset value	**121,580**	149,065
Commingled equity funds measured at net asset value	**245,509**	240,453
Alternative investments measured at net asset value	**196,121**	200,353
Pending purchases of alternative investments	**33,000**	–
Total fair value of plan assets at end of year	**$ 1,375,159**	$ 1,342,970

Fair value methodologies for Level 1 and Level 2 are consistent with the inputs described in Note 7.

Fixed income securities include debt obligations of the U.S. government and various agencies, U.S. corporations, and other fixed income instruments such as mortgage-backed and asset-backed securities. The composition of these securities represents an expected return and risk profile that is commensurate with broadly defined fixed income indexes such as the Barclays Capital U.S. Aggregate Index. Additionally, investments include mutual funds and commingled fixed-income funds that may also invest in opportunistic as well as non-U.S. and high-yield debt instruments. Commingled fixed-income funds are valued using net asset value as a practical expedient.

Common and preferred stocks include investments of publicly traded common stocks of both U.S. and international corporations, the majority of which represent actively traded and liquid securities that are traded on many of the world's major exchanges and include large-, mid-, and small-capitalization securities. The composition of these securities represents an expected return and risk profile that is commensurate with broadly defined equity indexes such as the Russell 3000 Index and the Morgan Stanley Capital International (MSCI) All Country World ex-U.S. Index. Investments also include equity mutual funds and commingled equity funds whose underlying assets may include publicly traded equity securities. Commingled equity funds are valued using net asset value as a practical expedient.

14. Pensions and Other Postretirement Benefits (continued)

Alternative investments include hedge funds and private equity funds that are valued using net asset value as a practical expedient. Hedge funds are meant to provide returns between those expected from stocks and fixed income investments with commensurate levels of risk and lower correlation relative to traditional investments. Included in this category are investments that are well diversified across various strategies and may consist of absolute return funds, long/short funds, and other opportunistic/multi-strategy funds. The underlying investments in such funds may include publicly traded and privately held equity and debt instruments issued by U.S. and international corporations as well as various derivatives based on these securities. Hedge fund redemptions typically contain restrictions that allow for a portion of the withdrawal proceeds to be held back from distribution while the underlying investments are liquidated. Private equity investments make up a smaller portion of the alternative investments and generally consist of limited partnerships formed to invest in equity and debt investments in operating companies that are not publicly traded. Investment strategies in this category may include buyouts, distressed debt, and venture capital. Private equity funds are closed-end funds and have significant redemption restrictions that prohibit redemptions during the fund's life.

15. Income Taxes

The Foundation and most of its controlled affiliates are tax-exempt organizations as described in Section 501(c)(3) of the Internal Revenue Code. These organizations are subject to income tax on any income from unrelated business activities. The System also owns or controls certain taxable affiliates.

The System files income tax returns in the U.S. federal jurisdiction and in various state and foreign jurisdictions. With few exceptions, the System is no longer subject to U.S. federal, state, and local or non-U.S. income tax examinations by tax authorities for years before 2013.

At December 31, 2017 and 2016, the liability for uncertainty in income taxes was $0.6 million and $2.3 million, respectively. The System does not expect a significant increase or decrease in unrecognized tax benefits within the next 12 months. The System recognizes interest and penalties accrued related to the liability for unrecognized tax benefits in the consolidated statements of operations and changes in net assets.

The System has gross net operating losses available for federal income tax purposes of $121.7 million and $121.5 million at December 31, 2017 and 2016, respectively. These losses expire in varying amounts from 2018 through 2037. A deferred tax asset of $25.6 million and $41.3 million relating to the net operating losses has been recorded at December 31, 2017 and 2016, respectively. A valuation allowance of $25.5 million and $41.3 million has been recorded at December 31, 2017 and 2016, respectively, related to the net operating loss carryforwards due to the uncertainty regarding their use.

15. Income Taxes (continued)

The Tax Cuts and Jobs Act (Act) was enacted on December 22, 2017. The Act reduces the U.S. federal corporate tax rate from 35% to 21%, requires companies to pay a one-time transition tax on earnings of certain foreign subsidiaries that was previously tax deferred and creates new taxes on certain foreign sourced earnings. For tax-exempt entities, the Act also requires organizations to categorize certain fringe benefit expenses as a source of unrelated business income, pay an excise tax on remuneration above certain thresholds that is paid to executives by the organization, and report income or loss from unrelated business activities on an activity-by-activity basis, among other provisions. At December 31, 2017, the System has made a reasonable estimate of the tax effects of the enactment of the Act. As a result, a tax benefit of $6.2 million was recorded for the remeasurement of the deferred tax balances at the new tax rate. Certain regulatory guidance provides for a measurement period of up to one year during which the accounting for the tax effects of the Act may be completed. The System may record further adjustments in future periods upon obtaining, preparing, or analyzing additional information about facts and circumstances that existed as of the date of enactment that would have affected the income tax effects initially reported. The System will continue to revise and refine the calculations as additional IRS guidance is issued.

16. Commitments and Contingent Liabilities

The System leases various equipment and facilities under operating lease arrangements. Total rental expense in 2017 and 2016 was $66.2 million and $73.6 million, respectively. Minimum operating lease payments over the next five years are as follows (in thousands): 2018 – $49,542; 2019 – $36,418; 2020 – $31,199; 2021 – $27,880; and 2022 – $24,344.

Included in the System's operating lease payments are the following off-balance-sheet financing agreements:

In 2003, the System entered into an operating lease agreement for the purpose of leasing a genetics and stem cell research building (Stem Cell Building Lease). Under the terms of the Stem Cell Building Lease, the System began to lease the facility upon the issuance of the certificate of occupancy in December 2004 and is required to lease the facility for 29 years. At December 31, 2017, total remaining minimum operating lease payments were $27.2 million.

In 2006, the System entered into an operating lease agreement for the purpose of leasing a parking garage and service center building (Service Center Lease). Under the terms of the Service Center Lease, the System began to lease the facility upon issuance of a certificate of occupancy in October 2008 and is required to lease the facility for 21 years with an option (by the System) to extend the lease an additional five years. At December 31, 2017, total remaining minimum operating lease payments were $71.3 million.

16. Commitments and Contingent Liabilities (continued)

In 2007, the System entered into two operating lease agreements to lease an office complex comprised of five buildings primarily used for administrative services, totaling approximately 707,000 square feet. The System is required to lease the facilities for 22 years with an option (by the System) to extend the leases an additional five years. At December 31, 2017, total remaining minimum operating lease payments were $37.4 million.

At December 31, 2017, the System has commitments for construction and other related capital contracts of $485.5 million and letters of credit of $0.7 million. Guarantees of mortgage loans made by banks to certain staff members are $18.5 million at December 31, 2017. In addition, the System has remaining commitments to invest approximately $635.4 million in alternative investments at December 31, 2017. The largest commitment at December 31, 2017, to any one alternative strategy manager is $81.0 million. These investments are expected to occur over the next three to five years. No amounts have been recorded in the consolidated balance sheets for these commitments and guarantees.

Pledge liabilities to various foundations and other entities at December 31, 2017 are as follows (in thousands): 2018 – $15,642; 2019 – $500; 2020 – $4,800; 2021 – $500; 2022 – $4,600; and thereafter – $13,700. The unamortized discount on pledge liabilities at December 31, 2017 was $4.0 million. Pledge liabilities are recorded in other current liabilities and other noncurrent liabilities in the consolidated balance sheets.

17. Endowment

The System's endowment consists of approximately 323 individual donor-restricted funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on donor-imposed restrictions.

17. Endowment (continued)

Interpretation of Relevant Law

In 2009, the Uniform Prudent Management of Institutional Funds Act (UPMIFA) was enacted to update and replace Ohio's previous law, the Uniform Management of Institutional Funds Act. The System has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the System classifies as permanently restricted net assets (1) the original value of gifts donated to the permanent endowment, (2) the original value of subsequent gifts to the permanent endowment, and (3) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the System in a manner consistent with the standard for expenditure prescribed by UPMIFA. In accordance with UPMIFA, the System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

1. The duration and preservation of the fund.
2. The purposes of the System and the donor-restricted endowment fund.
3. General economic conditions.
4. The possible effect of inflation and deflation.
5. The expected total return from income and the appreciation of investments.
6. Other resources of the System.
7. The investment policies of the System.

Funds With Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the System to retain as a fund of perpetual duration. Deficiencies of this nature that are reported in unrestricted net assets were $0.1 million and $0.6 million as of December 31, 2017 and 2016, respectively.

Return Objectives and Risk Parameters

The System has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the organization must hold in perpetuity. Under this policy, the endowment assets are invested in a highly diversified portfolio of U.S. and non-U.S. publicly traded equities, alternative investments, and fixed income securities structured to achieve an optimal balance between return and risk. The System expects its endowment funds, over time, to provide an average rate of return of approximately 7.5% annually. Actual returns in any given year may vary from this amount.

17. Endowment (continued)

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The System targets a diversified asset allocation to achieve its long-term return objective within prudent risk constraints.

Spending Policy and How the Investment Objectives Relate to Spending Policy

The System has a policy of appropriating for distribution each year up to 5% of its endowment fund's average fair value over the prior three years through the calendar year-end preceding the fiscal year in which the distribution is planned. In establishing this policy, the System considered the long-term expected return on its endowment. Accordingly, over the long term, the System expects the current spending policy to allow its endowment to grow at an average of 2.5% annually. This is consistent with the System's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

Changes in Endowment Net Assets

The following table summarizes the changes in endowment net assets for the years ended December 31, 2017 and 2016 (in thousands):

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, January 1, 2016	$ 38,787	$ 260,310	$ 299,097
Investment income	1,245	–	1,245
Net appreciation	14,521	–	14,521
Contributions	–	16,979	16,979
Appropriation of endowment assets for expenditure	(7,290)	–	(7,290)
Endowment net assets, December 31, 2016	47,263	277,289	324,552
Investment income	**2,251**	–	**2,251**
Net appreciation	**38,172**	–	**38,172**
Contributions	–	**22,160**	**22,160**
Appropriation of endowment assets for expenditure	**(5,325)**	–	**(5,325)**
Endowment net assets, December 31, 2017	**$ 82,361**	**$ 299,449**	**$ 381,810**

18. Functional Expenses

The System provides healthcare services and education and performs research. Expenses related to these functions were as follows (in thousands):

	2017	2016
Healthcare services	**$ 6,464,006**	$ 6,240,880
Research	**228,789**	220,137
Medical education	**334,563**	333,354
General and administrative	**959,399**	894,707
Non-healthcare services	**89,687**	104,890
	$ 8,076,444	$ 7,793,968

19. Special Charges

The System incurred and recorded special charges of $5.5 million and $25.6 million in 2017 and 2016, respectively. Special charges includes $5.5 million and $17.8 million in 2017 and 2016, respectively, of accelerated depreciation expense and other costs related to LHA. The Foundation, 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. 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 16 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 in 2016 also include $7.8 million of statutory compensation costs related to the termination of tenant leases at the System's London building that is being converted from office space to a healthcare facility.

20. Subsequent Events

The System evaluated events and transactions occurring subsequent to December 31, 2017 through March 29, 2018, 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)

	December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 27,644	$ 213,583	$ –	$ 241,227
Patient receivables, net	904,105	142,450	(33,652)	1,012,903
Due from affiliates	55,942	50	(55,992)	–
Investments for current use	103,920	51,051	–	154,971
Other current assets	310,960	64,134	(368)	374,726
Total current assets	1,402,571	471,268	(90,012)	1,783,827
Investments:				
Long-term investments	7,289,000	440,697	–	7,729,697
Funds held by trustees	69,234	–	–	69,234
Assets held for self-insurance	–	159,802	–	159,802
Donor-restricted assets	685,292	32,118	–	717,410
	8,043,526	632,617	–	8,676,143
Property, plant, and equipment, net	3,819,800	879,897	–	4,699,697
Other assets:				
Pledges receivable, net	150,690	329	–	151,019
Trusts and interests in foundations	71,866	8,777	–	80,643
Other noncurrent assets	566,548	60,388	(151,926)	475,010
	789,104	69,494	(151,926)	706,672
Total assets	$ 14,055,001	$ 2,053,276	$ (241,938)	$15,866,339

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. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

Unaudited Consolidating Balance Sheets (continued)

($ in thousands)

	December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable	$ 432,859	$ 71,024	$ (192)	$ 503,691
Compensation and amounts withheld from payroll	311,159	34,287	–	345,446
Current portion of long-term debt	77,208	380,677	(72)	457,813
Variable rate debt classified as current	514,396	58,874	–	573,270
Due to affiliates	50	55,942	(55,992)	–
Other current liabilities	358,475	116,352	(36,165)	438,662
Total current liabilities	1,694,147	717,156	(92,421)	2,318,882
Long-term debt:				
Hospital revenue bonds	2,861,438	–	–	2,861,438
Notes payable and capital leases	110,675	171,562	(147,397)	134,840
	2,972,113	171,562	(147,397)	2,996,278
Other liabilities:				
Professional and general liability insurance reserves	55,875	91,452	–	147,327
Accrued retirement benefits	453,710	39,123	–	492,833
Other noncurrent liabilities	526,814	40,752	–	567,566
	1,036,399	171,327	–	1,207,726
Total liabilities	5,702,659	1,060,045	(239,818)	6,522,886
Net assets:				
Unrestricted	7,397,798	950,971	(2,120)	8,346,649
Temporarily restricted	638,208	23,981	–	662,189
Permanently restricted	316,336	18,279	–	334,615
Total net assets	8,352,342	993,231	(2,120)	9,343,453
Total liabilities and net assets	$ 14,055,001	$ 2,053,276	$ (241,938)	$15,866,339

See notes to unaudited consolidated financial statements.

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Unaudited Consolidating Balance Sheets (continued)

($ in thousands)

	December 31, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 303,102	$ 217,526	$ –	$ 520,628
Patient receivables, net	980,244	105,228	(26,301)	1,059,171
Due from affiliates	4,091	28	(4,119)	–
Investments for current use	–	52,126	–	52,126
Other current assets	315,649	83,554	(2,311)	396,892
Total current assets	1,603,086	458,462	(32,731)	2,028,817
Investments:				
Long-term investments	6,090,613	385,646	–	6,476,259
Funds held by trustees	75,892	–	–	75,892
Assets held for self-insurance	–	128,128	–	128,128
Donor-restricted assets	572,982	39,239	–	612,221
	6,739,487	553,013	–	7,292,500
Property, plant, and equipment, net	3,678,818	833,260	–	4,512,078
Other assets:				
Pledges receivable, net	149,889	820	–	150,709
Trusts and interests in foundations	59,069	8,150	–	67,219
Other noncurrent assets	514,693	51,138	(155,824)	410,007
	723,651	60,108	(155,824)	627,935
Total assets	$ 12,745,042	$ 1,904,843	$ (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. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

Unaudited Consolidating Balance Sheets (continued)

($ in thousands)

	December 31, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable	$ 409,700	$ 75,037	$ (2,310)	$ 482,427
Compensation and amounts withheld from payroll	291,384	31,109	–	322,493
Current portion of long-term debt	75,918	5,893	(72)	81,739
Variable rate debt classified as current	466,203	60,912	–	527,115
Due to affiliates	28	4,091	(4,119)	–
Other current liabilities	388,227	100,636	(26,302)	462,561
Total current liabilities	1,631,460	277,678	(32,803)	1,876,335
Long-term debt:				
Hospital revenue bonds	2,926,949	–	–	2,926,949
Notes payable and capital leases	121,896	547,127	(152,304)	516,719
	3,048,845	547,127	(152,304)	3,443,668
Other liabilities:				
Professional and general liability insurance reserves	57,290	88,819	–	146,109
Accrued retirement benefits	429,965	48,909	–	478,874
Other noncurrent liabilities	434,093	56,452	–	490,545
	921,348	194,180	–	1,115,528
Total liabilities	5,601,653	1,018,985	(185,107)	6,435,531
Net assets:				
Unrestricted	6,253,358	838,299	(3,448)	7,088,209
Temporarily restricted	597,449	29,977	–	627,426
Permanently restricted	292,582	17,582	–	310,164
Total net assets	7,143,389	885,858	(3,448)	8,025,799
Total liabilities and net assets	$ 12,745,042	$ 1,904,843	$ (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. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

Unaudited Consolidating Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Unrestricted revenues				
Net patient service revenue	**$1,814,911**	**$ 227,032**	**$ (85,863)**	**$ 1,956,080**
Provision for uncollectible accounts	**(41,224)**	**(11,888)**	**–**	**(53,112)**
Net patient service revenue less provision for uncollectible accounts	**1,773,687**	**215,144**	**(85,863)**	**1,902,968**
Other	**190,197**	**75,042**	**(43,327)**	**221,912**
Total unrestricted revenues	**1,963,884**	**290,186**	**(129,190)**	**2,124,880**
Expenses				
Salaries, wages, and benefits	**1,063,304**	**148,525**	**(94,087)**	**1,117,742**
Supplies	**184,109**	**24,122**	**(524)**	**207,707**
Pharmaceuticals	**226,538**	**21,188**	**–**	**247,726**
Purchased services and other fees	**114,301**	**36,176**	**(9,701)**	**140,776**
Administrative services	**46,831**	**23,200**	**(7,762)**	**62,269**
Facilities	**68,786**	**14,985**	**(892)**	**82,879**
Insurance	**16,778**	**12,981**	**(16,199)**	**13,560**
	1,720,647	**281,177**	**(129,165)**	**1,872,659**
Operating income before interest, depreciation, and amortization expenses	**243,237**	**9,009**	**(25)**	**252,221**
Interest	**29,654**	**3,336**	**–**	**32,990**
Depreciation and amortization	**103,548**	**14,932**	**(25)**	**118,455**
Operating income (loss) before special charges	**110,035**	**(9,259)**	**–**	**100,776**
Special charges	**–**	**1,072**	**–**	**1,072**
Operating income (loss)	**110,035**	**(10,331)**	**–**	**99,704**
Nonoperating gains and losses				
Investment return	**231,015**	**17,360**	**–**	**248,375**
Derivative gains (losses)	**4,765**	**(548)**	**–**	**4,217**
Other, net	**(32,201)**	**(9,238)**	**–**	**(41,439)**
Net nonoperating gains	**203,579**	**7,574**	**–**	**211,153**
Excess (deficiency) of revenues over expenses	**313,614**	**(2,757)**	**–**	**310,857**

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

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

($ in thousands)

Operations

	Three Months Ended December 31, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Unrestricted revenues				
Net patient service revenue	$1,776,299	$ 251,653	$ (73,143)	$ 1,954,809
Provision for uncollectible accounts	(51,375)	(9,328)	–	(60,703)
Net patient service revenue less provision for uncollectible accounts	1,724,924	242,325	(73,143)	1,894,106
Other	168,924	81,160	(41,710)	208,374
Total unrestricted revenues	1,893,848	323,485	(114,853)	2,102,480
Expenses				
Salaries, wages, and benefits	1,025,036	140,755	(68,437)	1,097,354
Supplies	166,896	27,059	(289)	193,666
Pharmaceuticals	205,695	20,297	–	225,992
Purchased services and other fees	108,499	43,261	(20,991)	130,769
Administrative services	38,203	26,168	(7,879)	56,492
Facilities	69,793	18,896	(989)	87,700
Insurance	17,444	9,625	(16,268)	10,801
	1,631,566	286,061	(114,853)	1,802,774
Operating income before interest, depreciation, and amortization expenses	262,282	37,424	–	299,706
Interest	33,733	2,555	–	36,288
Depreciation and amortization	106,490	16,887	–	123,377
Operating income before special charges	122,059	17,982	–	140,041
Special charges	(1)	2,735	–	2,734
Operating income	122,060	15,247	–	137,307
Nonoperating gains and losses				
Investment return	37,706	839	–	38,545
Derivative gains (losses)	45,482	(624)	–	44,858
Other, net	(104,118)	(526)	–	(104,644)
Net nonoperating losses	(20,930)	(311)	–	(21,241)
Excess of revenues over expenses	101,130	14,936	–	116,066

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

($ in thousands)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Total net assets at October 1, 2016	$ 7,047,835	$ 853,705	$ (3,448)	$ 7,898,092
Excess of revenues over expenses	101,130	14,936	–	116,066
Donated capital, excluding assets released from restrictions for capital purposes	(239)	–	–	(239)
Restricted gifts and bequests	51,577	1,587	–	53,164
Restricted net investment income	3,324	26	–	3,350
Net assets released from restrictions used for operations included in other unrestricted revenues	(14,107)	(1,729)	–	(15,836)
Retirement benefits adjustment	(5,171)	(10,954)	–	(16,125)
Transfers (to) from affiliates	(44,364)	44,364	–	–
Change in restricted net assets related to interest in foundations	97	–	–	97
Change in restricted net assets related to value of perpetual trusts	2,732	175	–	2,907
Foreign currency translation gain (loss)	105	(16,066)	–	(15,961)
Other	470	(186)	–	284
Increase in total net assets	95,554	32,153	–	127,707
Total net assets at December 31, 2016	$ 7,143,389	$ 885,858	$ (3,448)	$ 8,025,799
Total net assets at October 1, 2017	**$ 7,949,290**	**$ 1,039,677**	**$ (3,448)**	**$ 8,985,519**
Excess (deficiency) of revenues over expenses	**313,614**	**(2,757)**	–	**310,857**
Restricted gifts and bequests	**41,586**	**632**	–	**42,218**
Restricted net investment income	**16,144**	**749**	–	**16,893**
Net assets released from restrictions used for operations included in other unrestricted revenues	**(13,944)**	**(1,269)**	–	**(15,213)**
Retirement benefits adjustment	**(5,282)**	**3,884**	–	**(1,398)**
Transfers from (to) affiliates	**49,481**	**(49,481)**	–	–
Change in restricted net assets related to interest in foundations	**1,411**	–	–	**1,411**
Change in restricted net assets related to value of perpetual trusts	**591**	**238**	–	**829**
Foreign currency translation gain	–	**2,189**	–	**2,189**
Other	**(549)**	**(631)**	**1,328**	**148**
Increase (decrease) in total net assets	**403,052**	**(46,446)**	**1,328**	**357,934**
Total net assets at December 31, 2017	**$ 8,352,342**	**$ 993,231**	**$ (2,120)**	**$ 9,343,453**

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. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

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

($ in thousands)

Operations

	Year Ended December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Unrestricted revenues				
Net patient service revenue	$7,151,809	$ 916,179	$ (273,437)	$ 7,794,551
Provision for uncollectible accounts	(240,971)	(55,498)	–	(296,469)
Net patient service revenue less provision for uncollectible accounts	6,910,838	860,681	(273,437)	7,498,082
Other	769,719	302,217	(163,016)	908,920
Total unrestricted revenues	7,680,557	1,162,898	(436,453)	8,407,002
Expenses				
Salaries, wages, and benefits	4,291,356	587,955	(314,171)	4,565,140
Supplies	693,166	101,572	(1,373)	793,365
Pharmaceuticals	872,841	84,204	–	957,045
Purchased services and other fees	435,791	126,802	(29,548)	533,045
Administrative services	151,282	70,462	(22,881)	198,863
Facilities	269,428	68,627	(3,684)	334,371
Insurance	66,917	58,839	(64,696)	61,060
	6,780,781	1,098,461	(436,353)	7,442,889
Operating income before interest, depreciation, and amortization expenses	899,776	64,437	(100)	964,113
Interest	128,956	11,868	–	140,824
Depreciation and amortization	424,771	62,569	(100)	487,240
Operating income (loss) before special charges	346,049	(10,000)	–	336,049
Special charges	–	5,491	–	5,491
Operating income (loss)	346,049	(15,491)	–	330,558
Nonoperating gains and losses				
Investment return	830,497	65,642	–	896,139
Derivative gains (losses)	44	(2,349)	–	(2,305)
Other, net	(70,802)	(3,276)	–	(74,078)
Net nonoperating gains	759,739	60,017	–	819,756
Excess of revenues over expenses	1,105,788	44,526	–	1,150,314

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

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

($ in thousands)

Operations

	Year Ended December 31, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Unrestricted revenues				
Net patient service revenue	$6,887,704	$ 923,407	$ (260,045)	$ 7,551,066
Provision for uncollectible accounts	(263,904)	(37,790)	–	(301,694)
Net patient service revenue less provision for uncollectible accounts	6,623,800	885,617	(260,045)	7,249,372
Other	641,776	307,632	(161,573)	787,835
Total unrestricted revenues	7,265,576	1,193,249	(421,618)	8,037,207
Expenses				
Salaries, wages, and benefits	4,126,743	576,451	(272,212)	4,430,982
Supplies	646,496	103,608	(1,031)	749,073
Pharmaceuticals	791,831	70,866	–	862,697
Purchased services and other fees	408,744	140,171	(42,808)	506,107
Administrative services	155,122	68,448	(26,612)	196,958
Facilities	276,000	71,361	(3,984)	343,377
Insurance	67,628	74,089	(74,971)	66,746
	6,472,564	1,104,994	(421,618)	7,155,940
Operating income before interest, depreciation, and amortization expenses	793,012	88,255	–	881,267
Interest	126,401	9,704	–	136,105
Depreciation and amortization	405,832	70,473	–	476,305
Operating income before special charges	260,779	8,078	–	268,857
Special charges	968	24,650	–	25,618
Operating income (loss)	259,811	(16,572)	–	243,239
Nonoperating gains and losses				
Investment return	375,676	28,515	–	404,191
Derivative losses	(20,130)	(2,694)	–	(22,824)
Other, net	(103,704)	(7,395)	–	(111,099)
Net nonoperating gains	251,842	18,426	–	270,268
Excess of revenues over expenses	511,653	1,854	–	513,507

Please refer to Management's Discussion and Analysis for a listing of the hospitals in the Obligated Group. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

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

($ in thousands)

Changes in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Total net assets at January 1, 2016	$ 6,676,176	$ 836,270	$ (3,448)	$ 7,508,998
Excess of revenues over expenses	511,653	1,854	–	513,507
Donated capital, excluding assets released from restrictions for capital purposes of $22,683	724	41	–	765
Restricted gifts and bequests	97,207	3,988	–	101,195
Restricted net investment income	22,755	1,696	–	24,451
Net assets released from restrictions used for operations included in other unrestricted revenues	(40,895)	(4,397)	–	(45,292)
Retirement benefits adjustment	(6,835)	(10,954)	–	(17,789)
Transfers (to) from affiliates	(116,453)	116,453	–	–
Change in restricted net assets related to interest in foundations	432	–	–	432
Change in restricted net assets related to value of perpetual trusts	(1,318)	(773)	–	(2,091)
Foreign currency translation loss	(73)	(59,108)	–	(59,181)
Other	16	788	–	804
Increase in total net assets	467,213	49,588	–	516,801
Total net assets at December 31, 2016	7,143,389	885,858	(3,448)	8,025,799
Excess of revenues over expenses	**1,105,788**	**44,526**	**–**	**1,150,314**
Restricted gifts and bequests	**118,562**	**2,109**	**–**	**120,671**
Restricted net investment income	**51,721**	**3,391**	**–**	**55,112**
Net assets released from restrictions used for operations included in other unrestricted revenues	**(38,081)**	**(3,594)**	**–**	**(41,675)**
Retirement benefits adjustment	**(7,257)**	**3,884**	**–**	**(3,373)**
Transfers (to) from affiliates	**(27,471)**	**27,471**	**–**	**–**
Change in restricted net assets related to interest in foundations	**5,047**	**–**	**–**	**5,047**
Change in restricted net assets related to value of perpetual trusts	**1,717**	**618**	**–**	**2,335**
Foreign currency translation gain	**–**	**29,301**	**–**	**29,301**
Other	**(1,073)**	**(333)**	**1,328**	**(78)**
Increase in total net assets	**1,208,953**	**107,373**	**1,328**	**1,317,654**
Total net assets at December 31, 2017	**$ 8,352,342**	**$ 993,231**	**$ (2,120)**	**$ 9,343,453**

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. Avon Hospital, which became a member of the Obligated Group in August 2017, is reported in the Obligated Group for all periods presented.

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Year Ended December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Operating activities and net nonoperating gains and losses				
Increase in total net assets	$ 1,208,953	$ 107,373	$ 1,328	$ 1,317,654
Adjustments to reconcile increase in total net assets to net cash provided by operating activities and net nonoperating gains and losses:				
Loss on extinguishment of debt	46,159	–	–	46,159
Retirement benefits adjustment	7,257	(3,884)	–	3,373
Net realized and unrealized gains on investments	(832,374)	(65,467)	–	(897,841)
Depreciation and amortization	424,771	65,992	(100)	490,663
Provision for uncollectible accounts	240,971	55,498	–	296,469
Foreign currency translation gain	–	(29,301)	–	(29,301)
Donated capital	–	–	–	–
Restricted gifts, bequests, investment income, and other	(177,047)	(6,118)	–	(183,165)
Transfers to (from) affiliates	27,471	(27,471)	–	–
Amortization of bond premiums and debt issuance costs	(3,118)	12	–	(3,106)
Net gain in value of derivatives	(26,509)	–	–	(26,509)
Changes in operating assets and liabilities:				
Patient receivables	(164,832)	(92,720)	7,351	(250,201)
Other current assets	(59,278)	19,521	49,930	10,173
Other noncurrent assets	(53,297)	(9,392)	(3,798)	(66,487)
Accounts payable and other current liabilities	5,764	70,258	(59,618)	16,404
Other liabilities	111,364	(18,969)	–	92,395
Net cash provided by operating activities and net nonoperating gains and losses	756,255	65,332	(4,907)	816,680
Financing activities				
Proceeds from long-term borrowings	1,118,137	2,710	(2,710)	1,118,137
Payments for advance refunding and redemption of long-term debt	(1,110,120)	–	–	(1,110,120)
Principal payments on long-term debt	(86,096)	(5,778)	7,617	(84,257)
Debt issuance costs	(8,173)	–	–	(8,173)
Change in pledges receivables, trusts and interests in foundations	(1,482)	276	–	(1,206)
Restricted gifts, bequests, investment income, and other	177,047	6,118	–	183,165
Net cash provided by financing activities	89,313	3,326	4,907	97,546
Investing activities				
Expenditures for property and equipment	(519,040)	(88,680)	–	(607,720)
Proceeds from sale of property and equipment	1,070	416		1,486
Net change in cash equivalents reported in long-term investments	(394,195)	31,682	–	(362,513)
Purchases of investments	(2,226,802)	(214,566)	–	(2,441,368)
Sales of investments	2,045,412	169,822	–	2,215,234
Transfers (to) from affiliates	(27,471)	27,471	–	–
Net cash used in investing activities	(1,121,026)	(73,855)	–	(1,194,881)
Effect of exchange rate changes on cash	–	1,254	–	1,254
Decrease in cash and cash equivalents	(275,458)	(3,943)	–	(279,401)
Cash and cash equivalents at beginning of year	303,102	217,526	–	520,628
Cash and cash equivalents at end of year	$ 27,644	$ 213,583	$ –	$ 241,227

See notes to unaudited consolidated financial statements.

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Unaudited Consolidating Statements of Cash Flows (continued)

($ in thousands)

	Year Ended December 31, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments and Eliminations	Consolidated
Operating activities and net nonoperating gains and losses				
Increase in total net assets	$ 467,213	$ 49,588	$ –	$ 516,801
Adjustments to reconcile increase in total net assets to net cash provided by operating activities and net nonoperating gains and losses:				
Loss on extinguishment of debt	–	3,925	–	3,925
Retirement benefits adjustment	6,835	10,954	–	17,789
Net realized and unrealized gains on investments	(356,893)	(25,253)	–	(382,146)
Depreciation and amortization	405,832	85,460	–	491,292
Provision for uncollectible accounts	263,904	37,790	–	301,694
Foreign currency translation loss	73	59,108	–	59,181
Donated capital	(724)	(41)	–	(765)
Restricted gifts, bequests, investment income, and other	(119,076)	(4,911)	–	(123,987)
Transfers to (from) affiliates	116,453	(116,453)	–	–
Amortization of bond premiums and debt issuance costs	(1,670)	13	–	(1,657)
Net gain in value of derivatives	(1,954)	(6,881)	–	(8,835)
Changes in operating assets and liabilities:				
Patient receivables	(364,728)	(48,474)	2,641	(410,561)
Other current assets	45,182	(17,099)	3,030	31,113
Other noncurrent assets	(191,171)	29,839	102,773	(58,559)
Accounts payable and other current liabilities	98,026	(431)	(5,671)	91,924
Other liabilities	23,621	(14,693)	–	8,928
Net cash provided by operating activities and net nonoperating gains and losses	390,923	42,441	102,773	536,137
Financing activities				
Proceeds from long-term borrowings	502,370	145,711	(145,633)	502,448
Payments for advance refunding and redemption of long-term debt	–	(148,260)	–	(148,260)
Principal payments on long-term debt	(143,228)	(26,643)	42,860	(127,011)
Debt issuance costs	(949)	–	–	(949)
Change in pledges receivables, trusts and interests in foundations	(11,510)	1,307	–	(10,203)
Restricted gifts, bequests, investment income, and other	119,076	4,911	–	123,987
Net cash provided by (used in) financing activities	465,759	(22,974)	(102,773)	340,012
Investing activities				
Expenditures for property and equipment	(614,364)	(50,339)	–	(664,703)
Proceeds from sale of property and equipment	1,585	–	–	1,585
Net change in cash equivalents reported in long-term investments	91,241	54,823	–	146,064
Purchases of investments	(2,375,754)	(381,917)	–	(2,757,671)
Sales of investments	2,351,802	320,101	–	2,671,903
Transfers (to) from affiliates	(116,453)	116,453	–	–
Net cash (used in) provided by investing activities	(661,943)	59,121	–	(602,822)
Effect of exchange rate changes on cash	(73)	(2,206)	–	(2,279)
Increase in cash and cash equivalents	194,666	76,382	–	271,048
Cash and cash equivalents at beginning of year	108,436	141,144	–	249,580
Cash and cash equivalents at end of year	$ 303,102	$ 217,526	$ –	$ 520,628

See notes to unaudited consolidated financial statements.

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Utilization

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

	Year Ended December 31		
	2015[2]	2016	2017
Total Staffed Beds[1]	4,034	3,931	3,847
Percent Occupancy[1]	67.9%	69.3%	70.7%
Inpatient Admissions[1]			
Acute	146,990	162,930	169,238
Post-acute	11,779	12,424	11,710
Total	158,769	175,354	180,948
Patient Days[1]			
Acute	782,316	846,170	877,891
Post-acute	98,268	103,979	93,961
Total	880,584	950,149	971,852
Average Length of Stay			
Acute	5.30	5.20	5.16
Post-acute	8.30	8.39	8.04
Surgical Facility Cases			
Inpatient	56,311	59,802	61,529
Outpatient	137,139	147,855	145,825
Total	193,450	207,657	207,354
Emergency Room Visits	542,768	652,073	644,575
Outpatient Observations	49,237	58,384	59,894
Outpatient Evaluation and Management Visits	3,742,901	4,235,729	4,403,635
Acute Medicare Case Mix Index - Health System	1.91	1.93	1.91
Acute Medicare Case Mix Index - Cleveland Clinic	2.47	2.53	2.59
Total Acute Patient Case Mix Index - Health System	1.81	1.84	1.85
Total Acute Patient Case Mix Index - Cleveland Clinic	2.36	2.45	2.52

(1) Acute and post-acute, including rehabilitative and psychiatric services within post-acute, but excluding newborns and bassinets.

(2) 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		
	2015	**2016**	**2017**
Total Staffed Beds[(1)]	3,352	3,412	3,352
Percent Occupancy[(1)]	69.6%	69.6%	70.8%
Inpatient Admissions[(1)]			
Acute	138,287	139,300	145,479
Post-acute	9,740	9,471	8,980
Total	148,027	148,771	154,459
Patient Days[(1)]			
Acute	747,231	744,296	767,003
Post-acute	73,473	76,113	70,567
Total	820,704	820,409	837,570
Surgical Facility Cases			
Inpatient	53,839	54,072	56,030
Outpatient	132,800	135,918	133,893
Total	186,639	189,990	189,923
Emergency Room Visits	493,930	535,478	530,316
Outpatient Observations	45,687	50,671	52,506
Outpatient Evaluation and Management Visits	3,742,901	4,232,729	4,399,738
Acute Medicare Case Mix Index	1.86	1.91	1.90
Total Acute Patient Case Mix Index	1.76	1.83	1.84

(1) Acute and post-acute, including rehabilitative and psychiatric services within post-acute, but excluding newborns and bassinets.

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:

	Year Ended December 31		
	2015[(1)]	2016	2017
Payor			
Managed Care and Commercial	42%	39%	38%
Medicare	43%	44%	46%
Medicaid	12%	14%	14%
Self-Pay & Other	3%	3%	2%
Total	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31		
	2015	2016	2017
Payor			
Managed Care and Commercial	42%	40%	39%
Medicare	43%	44%	46%
Medicaid	12%	13%	13%
Self-Pay & Other	3%	3%	2%
Total	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		
	2015	**2016**	**2017**
External Grants Earned			
Federal Sources	$103,022	$108,253	$114,942
Non-Federal Sources	81,796	87,883	92,564
Total	184,818	196,136	207,506
Internal Support	63,240	59,326	59,873
Total Sources of Support	$248,058	$255,462	$267,379

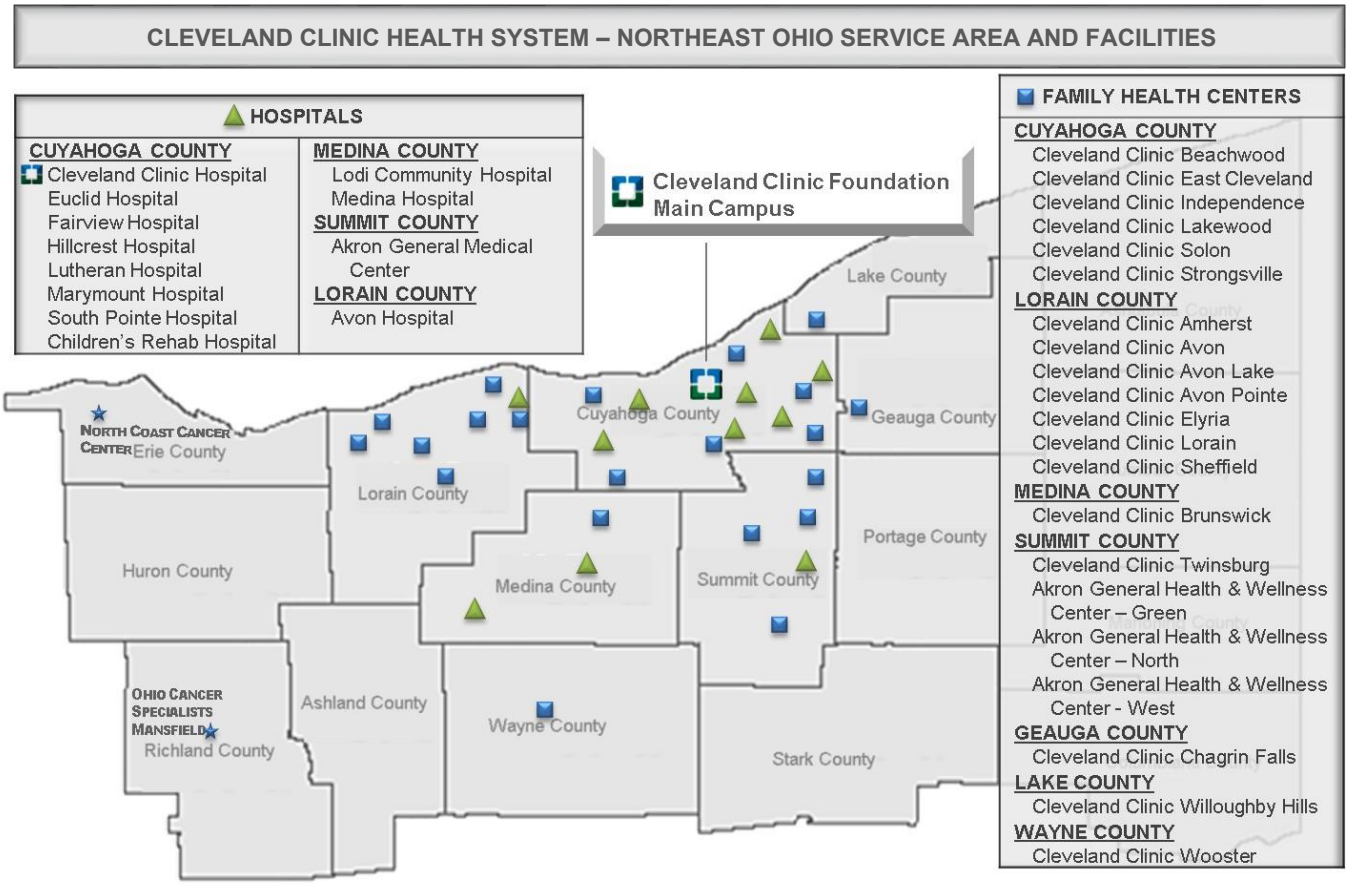
Key Ratios

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

	Year Ended December 31		
	2015	**2016**	**2017**
Liquidity ratios			
Days of cash on hand	347	349	383
Days of revenue in accounts receivable	47	51	49
Coverage ratios			
Cash to debt (%)	168.9	172.7	197.9
Maximum annual debt service coverage (x)	5.7	3.8	5.3
Interest expense coverage (x)	10.1	7.5	9.1
Debt to cash flow (x)	3.4	4.6	3.5
Leverage ratio			
Debt to capitalization (%)	36.5	36.4	32.5
Profitability ratios			
Operating margin (%)	6.7	3.0	3.9
Operating cash flow margin (%)	14.7	11.0	11.5
Excess margin (%)	8.5	6.2	12.5
Return on assets (%)	4.5	3.6	7.3

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 135 other countries in 2017. The System operates 13 hospitals with approximately 3,800 staffed beds and is the leading provider of healthcare services in northeast Ohio. Twelve of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates 21 outpatient Family Health Centers and 10 ambulatory surgery centers, as well as numerous physician offices, which are 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, and 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 364 staffed beds.



The following table sets forth the hospitals currently operated by the obligated issuers and their affiliates, together with each hospital's staffed bed count as of December 31, 2017:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,275
Avon Hospital[(1)]	126
Euclid Hospital	165
Fairview Hospital	460
Hillcrest Hospital	440
Lutheran Hospital	194
Marymount Hospital	277
Medina Hospital	121
South Pointe Hospital	139
Weston Hospital	155
	3,352
NON-OBLIGATED	
Akron General Medical Center	450
Children's Rehab Hospital	25
Lodi Hospital	20
	495
HEALTH SYSTEM	3,847

(1) Avon Hospital became an obligated issuer concurrently with the issuance of the Series 2017 Bonds. Refer to "FINANCING DEVELOPMENTS" for additional information.

AWARDS & RECOGNITION

The Clinic was ranked as the second best hospital in the United States by *U.S. News and World Report* in its 2017-2018 edition of "America's Best Hospitals." This is the nineteenth 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-three consecutive years. The Clinic has additionally received the honor of being recognized with the best urology program in the United States. This program was ranked second in the United States last year. The Clinic was nationally ranked in fourteen specialties, including ten in the top five nationwide, and is one of just twenty hospitals to earn a place on the *U.S. News'* 2017-2018 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 2017-2018 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 four of the System's regional hospitals in the top hospitals in the Cleveland metropolitan area and Ohio: Fairview Hospital ranked third in Cleveland and sixth in Ohio; Hillcrest Hospital ranked fourth in Cleveland and seventh in Ohio; and Marymount and South Pointe Hospitals both ranked sixth in Cleveland and twenty-fourth in Ohio. Akron General Medical Center, located in Summit County, was ranked tenth in the State of Ohio. Weston Hospital was ranked second in the Miami-Fort Lauderdale metro area and eighth out of more than 250 hospitals in the State of Florida.

In 2018, the Clinic was named one of the World's Most Ethical Companies by the Ethisphere Institute for the sixth 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.

In May 2017, the Clinic performed its third face transplant, and first total face transplant, on a 21-year old patient. Performed by a group of eleven physicians and a team of specialists, the surgery

included transplantation of the scalp, the forehead, upper and lower eyelids, eye sockets, nose, upper cheeks, upper jaw and half of lower jaw, upper and lower teeth, partial facial nerves, facial muscles and skin, effectively replacing 100 percent of the patient's facial tissue. In 2008, the Clinic was the first U.S. Hospital to perform a face transplant. The Clinic is one of six U.S. institutions that has conducted face transplants.

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 Clinic was recently recognized by the American College of Surgeons National Surgical Quality Improvement Program's (ACS NSQIP®) Meritorious Outcomes Performance designation. This distinction is given to only ten percent of the 680 participating hospitals that have achieved a quality score in eight surgical outcomes during the 2016 performance period. This is the second year the Clinic has received this award.

South Pointe Hospital achieved Magnet status recognition from the American Nurses Credentialing Center. Magnet status is the highest national credential for nursing excellence and serves as the gold standard for nursing practice. Organizations that have achieved Magnet status are recognized for quality in patient care, nursing excellence and innovations in professional nursing practice. South Pointe is the System's fourth hospital to receive Magnet designation. The Clinic received its first designation in 2003, Fairview Hospital was designated in 2009, and Hillcrest was designated in 2014.

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.

The Plain Dealer newspaper recognized the System as one of Northeast Ohio's 150 top workplaces, ranking it fifteenth in the category for large local employers. This list was based on the opinions of employees who responded to a survey that measured several aspects of workplace culture, including alignment with the organization, execution of strategies and feelings of connection. This is the System's fifth time on this list.

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

In October 2017, the Clinic and Marymount Hospital were included on a list of 60 of the greenest Hospitals in America compiled by

Becker's Hospital Review. The list recognizes hospitals for their leadership in sustainability and energy management. A number of factors were considered for the recognition, including sustainability efforts, commitment to the Healthier Hospitals Initiative and awards received from the Environmental Protection Agency, U.S. Green Building Council and Practice Greenhealth.

FINANCING DEVELOPMENTS

In August 2017, pursuant to certain agreements between the System and the State of Ohio (State) acting by and through the Ohio Higher Education Facility Commission, the State issued $818.8 million of Hospital Refunding Revenue Bonds (Series 2017A Bonds) and $169.3 million of Taxable Hospital Refunding Revenue Bonds (Series 2017B Bonds) for the benefit of the System. Proceeds from the sale of the Series 2017A Bonds and Series 2017B Bonds were used to refund all or a portion of the outstanding Series 2008A, 2008B, 2009A, 2009B and 2012A Bonds and to pay the cost of issuance. The Series 2017A Bonds and Series 2017B Bonds were assigned ratings of Aa2 and AA by Moody's Investor Services (Moody's) and Standard & Poor's (S&P), respectively.

At the time the Series 2017A Bonds and Series 2017B Bonds were rated, Moody's affirmed the Aa2 rating on the System's obligated group outstanding debt and maintained their stable outlook. Moody's cited various factors to support this rating and outlook, including a national and international clinical reputation, a leading market position in northeast Ohio, significant growth in unrestricted investments, history of strong cashflow margins and exceptional fundraising abilities. In its report, Moody's indicated that these strengths compensate for challenges such as relatively high debt levels for the rating category, competition in the consolidated northeast Ohio region and a weak local economy.

At the time the Series 2017A Bonds and Series 2017B Bonds were rated, S&P raised its rating on the System's obligated group outstanding debt to AA from AA- and changed its outlook to stable from positive. S&P cited various reasons for the upgrade, including the System's strong governance and management, a very strong enterprise profile and a strong financial profile that is characterized by consistent financial margins and solid liquidity. S&P noted the System's robust research program, increasing emphasis on teaching, widespread brand recognition of the heart and other select tertiary and quaternary service programs and very strong philanthropic support. Challenges to the current rating include northeast Ohio's unfavorable demographic trend, the System's robust capital spending program and a highly competitive service area in northeast Ohio.

In August 2017, concurrently with the issuance of the Series 2017A Bonds and Series 2017B Bonds, Avon Hospital became a member of the obligated group. For a description of Avon Hospital, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

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 five 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 30 Directors (currently there are 29 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 13 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 has a president, and all hospital presidents report the President of Regional Hospitals and Family Health Centers.

Toby Cosgrove, MD, former President and Chief Executive Officer (CEO) of the Clinic, announced in May 2017 that he would transition out of the top executive role. In September 2017, the Clinic's Board of Directors and Board of Governors unanimously selected Dr. Tomislav Mihaljevic based on the unanimous recommendation of a nomination committee that conducted an extensive review of potential successors. Refer to "APPOINTMENTS" for a description of Dr. Mihaljevic's background and experience. Drs. Cosgrove and Mihaljevic worked on a transition process together through the end of 2017. Effective January 1, 2018, Dr. Mihaljevic assumed the full duties of president and CEO, while Dr. Cosgrove serves in an advisory role.

APPOINTMENTS

Tomislav "Tom" Mihaljevic, MD has been appointed Chief Executive Officer and President of the Cleveland Clinic effective January 1, 2018. Dr. Mihaljevic joined the Clinic in 2004 as a cardiothoracic surgeon specializing in minimally invasive and robotically assisted cardiac surgeries. Since 2015, Dr. Mihaljevic had served as CEO of Cleveland Clinic Abu Dhabi, overseeing the hospital's strategy and operations, including directly managing the hospital's patient experience and strategy and business development programs. Dr. Mihaljevic's early experiences include medical studies and training in Croatia and Switzerland, a surgical residency at Boston's Brigham and Women's Hospital, and leadership and teaching roles at Harvard Medical School. He is the author or co-author of more than 145 articles in medical and peer-reviewed scientific journals and is the author of numerous textbook chapters on robotic and minimally invasive mitral valve surgery and heart valve disease.

Brian Donley, MD has been appointed Chief Executive Officer of Cleveland Clinic London effective February 2018. As CEO of Cleveland Clinic London, Dr. Donley will direct strategy and operations, guide recruitment and lead the opening of the new healthcare facility in London. Dr. Donley has served as Chief of Staff and Chief of Clinical Operations at the Clinic since 2015. He joined the Clinic's Orthopaedic and Rheumatologic Institute in 1996 and has served in various leadership roles over the years, including President of the Regional Hospitals and Family Health Centers. He is an orthopaedic surgeon specializing in foot and ankle surgery and has also served as Professor of Surgery at the Lerner College of Medicine of Case Western Reserve University. In 2013, Dr. Donley completed an Advanced Management Program at Harvard Business School.

Rakesh Suri, MD was appointed Acting Chief Executive Officer of Cleveland Clinic Abu Dhabi in October 2017. Subsequently, Dr. Suri was appointed CEO as Dr. Mihaljevic transitioned into the Clinic CEO role. Dr. Suri joined the Clinic in 2015 and served as Chief of Staff of Cleveland Clinic Abu Dhabi, where he led the recruitment of more than 400 physicians and participated in the opening and initiation of clinical services through the hospital. Dr. Suri's early experiences include medical studies and training in Canada and the United Kingdom.

Herbert Wiedemann, MD has been appointed Chief of Staff effective March 2018. Dr. Wiedemann joined the Clinic in 1984 and has served as Chairman of the Respiratory Institute since 2007. He also served as a member of the Board of Governors.

Edmund Sabanegh, MD has been appointed to the new role of President – Cleveland Clinic Main Campus effective March 2018. Dr. Sabanegh joined the Clinic in 2006 and has served as Associate Chief of Staff, Chairman of the Department of Urology and as a member of the Board of Governors. In March 2018, Dr. Sabanegh was also named interim President of the Regional Hospitals and Family Health Centers.

James Young, MD has been appointed Chief Academic Officer effective March 2018 and will oversee education and research across the System. Dr. Young joined the Clinic in 1995 and has served as Professor of Medicine and Executive Dean of Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. Dr. Young also chairs the Endocrinology and Metabolism Institute.

Margaret McKenzie, MD was appointed President of South Pointe Hospital in May 2017. 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.

Daniel Napierkowski, MD was appointed President of Marymount Hospital in May 2017. Dr. Napierkowski succeeds Richard Parker, MD, who now serves as President of Hillcrest Hospital and the East Region. Dr. Napierkowski has served as President of Euclid Hospital since May 2015 and has also previously served as the chairman of Regional Practice Anesthesiology. Until his successor is named, he will serve as President of both Marymount and Euclid Hospitals. He also currently serves on a number of the Clinic's committees.

Richard Shewbridge, MD was appointed President of Medina Hospital in July 2017. Dr. Shewbridge succeeds Thomas Tulisiak, MD, who returned to full-time clinical practice. Dr. Shewbridge joined the Clinic staff in 2010 and most recently served as Associate Chief Quality Officer for Regional Hospitals and Vice President of Medical Operations at Medina Hospital. He has participated on a number of Clinic and Medina Hospital clinical committees and projects, including serving on the advisory committee of the Medical Executive Committee from 2012-2016.

Edward Marx was appointed Chief Information Officer in September 2017. In this role, Mr. Marx leads the System's information technology strategy, working with clinical partners and caregivers across the System to enhance patient care through innovative technologies. Mr. Marx most recently served as Executive Vice President at the Advisory Board Company, where he provided information technology leadership and strategy to hospitals in New York City.

Amy Merlino, MD was appointed Enterprise Clinical Medical Information Officer in the Information Technology Division in April 2017. 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.

Christopher Connell was appointed Chief Design Officer in June 2017. Mr. Connell joined the Clinic from Foster + Partners architectural firm in London. While working at Foster + Partners, Connell was involved in the creation of the Cleveland Clinic Master Plan, a road map for future campus development. He was also involved with the design of the Clinic's health education campus. In this newly created role, Mr. Connell will be responsible for the creation, strategic alignment and execution of architecture and other design initiatives to create serene, restorative environments.

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 16 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 the third quarter of 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 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 to sixty days after the opening of the family health center and emergency department.

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. The lawsuit was dismissed on July 10, 2017 but was appealed, and the appeal is pending. 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. It was 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 the Taussig Cancer Center, 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 was completed in the fourth quarter of 2017 to connect the garage to the Clinic's facilities. The cost of the garage and connecting bridge was approximately $49 million.

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 is expected to 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. Marymount and Medina Hospitals implemented EAPM in the second quarter of 2017, and Akron General Medical Center and Lodi Hospital implemented EAPM in the third quarter of 2017. Implementation for the other System hospitals is planned in phases throughout 2018. EAPM is expected to require capital costs of approximately $186 million over the entire implementation period, most of which have already been incurred and paid.

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 the third quarter of 2018.

Coral Springs Family Health Center and Surgery Center - Cleveland Clinic Florida has partnered with a local Florida developer in a joint venture to construct a new Family Health Center and Surgery Center 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 third quarter of 2018 with a total estimated cost of $32 million. The joint venture obtained a loan for the majority of the construction costs. 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 a clinical decision unit for patients that need short-term observation care. 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 $55 million. Construction of the building began in the first quarter of 2017, and the emergency department is expected to be completed in third quarter of 2018. The clinical decision unit on the second floor of the facility is expected to have capacity for up to 18 short-term observation patient beds and is scheduled to open in the fourth 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 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 be completed in December 2018, with the first students expected to be enrolled in the summer of 2019. CWRU and the Clinic will share in the construction costs of approximately $449 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 three-story, 126,000 square-foot dental clinic that will be adjacent to the medical school facility and will cost approximately $66 million. The dental clinic will provide a space where students can treat patients under dental faculty supervision. Construction of the dental clinic broke ground in October 2017, and the facility is expected to open at the same time as the medical school.

Cleveland Clinic Children's – In early 2017, the Clinic started a transformation of the former Taussig Cancer Building on the Clinic's main campus into an outpatient facility for Cleveland Clinic Children's. The project consolidates multiple locations and specialties of Cleveland Clinic Children's ambulatory care into the existing building, including primary and specialty outpatient services, a children's retail pharmacy, pediatric lab services and pediatric radiology services with x-ray and ultrasound testing. It will also feature a family focused education center, sibling drop-off, pediatric nutrition center, an expanded front entrance on Euclid Avenue, and new technologies focused on enhancing the care and experience for patients, families and caregivers. The 120,000 square foot facility is expected to have 60 exam rooms, 20 infusion rooms, and four procedure rooms. Outpatient services will include adolescent medicine, allergy and immunology, behavioral health, cardiology and CT Surgery, dermatology, developmental medicine, endocrinology/diabetes, fetal care center, gastroenterology, general surgery, genetics, gynecology, hematology/oncology, infectious disease, integrative medicine, maternal fetal medicine, nephrology, neurology and neurosurgery, otolaryngology, physical medicine and rehabilitation, plastic surgery, primary care, psychiatry, pulmonary medicine, sleep disorders and urology. The renovation project including building infrastructure upgrades is projected to cost approximately $36 million and is scheduled to open in the third quarter of 2018.

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 December 31, 2017, the Clinic has received pledges, cash and other assets of approximately $1.3 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 recently completed Avon Hospital and Taussig Cancer Center, 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 into products that benefit patients around the world. 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 82 companies, transacted more than 534 technology licenses, filed over 3,900 patent applications with over 1,300 issued patents, and acted on approximately 3,600 new inventions. In 2017, Cleveland Clinic executed 43 transactions to provide Cleveland Clinic inventions to external organizations for development and commercialization in various fields, including orthopaedics, telemedicine, cardiovascular, immunology and concussion management.

In 2017, 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 develop 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. NaviGate developed the GATE™ tricuspid AVS based on a license of the seminal technology from the Clinic. In June 2017, two First-in-Man studies were successfully completed in Germany using the Kapsus catheter, a novel trans-septal puncture device developed by Bavaria Medizin Technologie GmbH (BMT), based on licensed technology invented by Samir Kapadia, MD of the Heart and Vascular Institute.

Cleveland Clinic Ventures operates in tandem with Cleveland Clinic Innovations to turn medical breakthrough inventions into products and companies. The strategy of Cleveland Clinic Ventures is 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.

Cleveland Clinic Innovations manages the Healthcare Innovations Alliance, a collaborative network of healthcare systems, academic institutions and industry partners from around the nation. Alliance partners utilize the Clinic's comprehensive technology and commercialization experience to turn medical ideas into marketable inventions and commercial ventures. The integration of capabilities between organizations is focused on discovery, development and rapid deployment of new technologies with the goal of improving patient care. In 2017, a new product development partner was added to the Alliance to bring expertise in electronics manufacturing to select Cleveland Clinic inventions. In October 2017, Cleveland Clinic Innovations announced a

partnership between the Clinic, Jumpstart Inc., and Plug & Play, a Silicon Valley-based accelerator. With the Clinic's support, Plug & Play is expected to launch a new HealthTech Accelerator located at the Global Center for Health Innovation in downtown Cleveland. The accelerator intends to connect innovative healthcare companies from all over the nation with investors and corporate partners.

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 2017 Medical Innovation Summit was held in October 2017 in downtown Cleveland. The Summit and its affiliated events had approximately 2,600 attendees, who discussed the future of healthcare and the latest opportunities and challenges in the genomics and precision medicine markets. The Summit also unveiled the Top 10 Medical Innovations of 2018, which highlights the potential for medical breakthroughs in the coming year. The "Top 10" has been led by Cleveland Clinic Innovations since its debut in 2007. Each year, Cleveland Clinic Innovations interviews over 75 Cleveland Clinic experts to elicit more than 150 nominations, which are presented, debated, and ranked in a series by two separate committees of clinical experts that vote on the combined lists to establish the Top 10 Medical Innovations.

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 tenth anniversary in February 2017 and has supported the development of over 50 technologies and the creation of over 1,000 new jobs.

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.

Boston Children's Hospital and the Clinic have entered an agreement to provide pediatric heart services through the Clinic's national network, which is a national-scale network of selected high-value cardiovascular care providers to contract with employers and other payers. This collaboration is expected to offer complex pediatric care to employers in the Clinic's national networks. Under the agreement, Boston Children's Hospital has special status in the network, participating in leadership of the pediatric program and sharing best practices related to patient care, outcome measurement, quality reporting and clinical research.

In January 2018, the Clinic entered into a cardiovascular affiliation agreement with Martin Health System based in Florida. Martin Health System is a regional not-for-profit, community-based healthcare provider with three acute-care hospitals and a network of outpatient services. The Clinic's Sydell and Arnold Miller Family Heart and Vascular institute and Martin Health System's Frances Langford Heart Center plan to share best practices in cardiology and heart surgery while focusing on providing high quality,

safe care and improved outcomes. The Clinic will also provide management services, such as clinical direction, quality assurance and access to technologies and techniques.

In January 2018, the Clinic entered into a clinical management and professional services agreement with Avita Health System based in Ohio. Avita Health System is a regional not-for-profit, community-based healthcare provider with two critical access hospitals and one acute care hospital and a network of outpatient services. The Clinic's Taussig Cancer Institute and Avita Health System plan to share best practices in medical oncology while focusing on providing high quality, safe care and improved outcomes. The Clinic will also provide certain professional and management services, such as clinical direction, quality assurance and access to technologies and techniques.

JOINT VENTURES

Under a joint venture agreement with Select Medical, the Clinic and Select Medical operate three rehabilitation hospitals in Northeast Ohio. The first hospital opened in December 2015 in Avon, Ohio. A second facility opened in Beachwood, Ohio in October 2017 and a third-facility opened in Bath Township, Ohio in November 2017, which is the successor location for the Edwin Shaw Rehabilitation Institute. Each 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. These facilities expand inpatient rehabilitation services in Northeast Ohio and improve access for patients with complex rehabilitation needs. Select Medical is one of the nation's largest providers 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.

In July 2016, the Clinic entered into a joint venture agreement with Select Medical to operate four existing 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 combines the experience of both organizations in the treatment of LTAC patients.

MEDICAID MANAGED CARE

In August 2017, Molina Healthcare of Ohio and the Clinic announced that Molina will include the Clinic in its Medicaid network effective August 1, 2017. This is the first time the Clinic and Molina Healthcare of Ohio have contracted for Medicaid coverage. The new relationship allows Molina to provide its Medicaid customers with additional options to access patient care at the Clinic.

In November 2017, CareSource and the Clinic signed a long-term contract so that CareSource Medicaid and MyCare members can continue to have their care covered at the Clinic. CareSource is the largest of five providers of Medicaid managed care plans in Ohio and accounted for approximately 66% of the Medicaid net patient service revenue of the System (or approximately 5% of net patient service revenue of the System) for the year ended December 31, 2016.

ACCOUNTABLE CARE ORGANIZATION

Cleveland Clinic Medicare ACO, LLC is an Accountable Care Organization (ACO) that includes participation from Cleveland Clinic physicians and independent Quality Alliance physicians that come together with hospitals and other providers to provide coordinated, high quality care to Medicare patients as part of the Medicare Shared Savings Program. The Shared Savings Program rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care. Initiatives of the Cleveland Clinic Medicare ACO include decreased utilization of inpatient and skilled nursing beds, better blood pressure control, improved management of diabetes and a significant decrease in admissions for asthma/COPD, chronic heart failure and 30-day readmissions. Cleveland Clinic Medicare ACO saved more than $42.2 million across 71,113 Medicare beneficiaries in 2016, of which it received $19.9 million in shared savings payments from Medicare. In 2015, the first year of operation, Cleveland Clinic Medicare ACO saved approximately $34 million, of which it received $16.6 million in shared savings payments. The 2015 results ranked first for first-year ACOs and sixth nationally among all Shared Savings Program participants.

In 2018, Cleveland Clinic Medicare ACO will transition to a new payment model for its approximately 105,000 beneficiaries that increases its opportunity for performance-based savings, while assuming limited performance based downside risk if it does not reach a specific savings benchmark. The downside risk is a fixed 30% loss-sharing rate, and in exchange the Clinic will be able to share higher savings based on quality performance.

CO-BRANDED INSURANCE

In June 2017, the Clinic entered into a collaboration with Oscar Health, a health insurance technology company based in New York City, to offer co-branded health insurance plans to consumers in five counties across northeast Ohio. The new Cleveland Clinic Oscar individual health plans are available through the Ohio health insurance exchange or directly through Oscar Health. Enrollment in the plans began in the 2018 open enrollment period with coverage beginning on January 1, 2018. More than 11,000 members enrolled during the open enrollment period, which was higher than original expectations and accounted for about 15% of the individual health insurance market in the five-county northeast Ohio area. Plan participants are matched with teams from both organizations that work together across the continuum of care to ensure that participant's health and wellness needs are proactively met. Participants have access to various technology to analyze and manage their health needs, including the option of telehealth virtual visits through Cleveland Clinic Express Care Online and Oscar's Virtual Visits.

In November 2017, Humana Inc., a leading health and well-being company, and the Clinic announced the creation of two new $0 premium Medicare Advantage health plans. The Humana Cleveland Clinic Preferred Medicare Plans will offer patient-centered, affordable access to expert doctors, nurses and facilities for people with Medicare in Cuyahoga County. The collaboration integrates Humana's Medicare Advantage experience with the Clinic's clinical

expertise. The plans offer a $0 monthly premium, $0 primary care physician office visit copay, $0 copay for a 30-day supply of Tier-1 prescription drugs and require no referrals to see in-network specialists. Plan members will have access to the Health System's physicians, specialties and facilities, as well as independent physicians who are part of the Cleveland Clinic Quality Alliance.

AKRON GENERAL HEALTH SYSTEM

In November 2015, the Clinic 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, three health and wellness centers, Visiting Nurse Services and affiliates, a physician group practice and other outpatient locations. As part of the original affiliation agreement, the Clinic and Akron General 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.

During the operational integration process in early 2016, a compliance review conducted by the System of contractual relationships between Akron General and its independent physician practice groups identified a group of physician arrangements that were potentially non-compliant with the Federal Anti-Kickback Statute and the Limitations on Certain Physician Referrals regulation (commonly referred to as the Stark Law). Any noncompliance may have resulted in false claims to federal and/or state health care programs beginning in 2010 and could result in liability of Akron General under the Federal Anti-Kickback Statute, Stark Law, False Claims Act and/or other laws and regulations. The System voluntarily disclosed its concerns about these physician arrangements to the U.S. Department of Justice (DOJ) in May 2016. Akron General and the System have produced information to, engaged in discussions with, and are cooperating with the DOJ and related government authorities in connection with this matter.

Although corrective actions have been taken by Akron General related to all of the physician arrangements at issue, and the Clinic has implemented its compliance programs at Akron General, there is a probable liability associated with the matters described above. Preliminary discussions with the DOJ and related government authorities about the physician arrangements are ongoing, and thus neither a timeframe for completion of the inquiry by the government authorities nor the ultimate amount of any fines, penalties and other potential financial liability, if any, that may arise under the Federal Anti-Kickback Statute, Stark Law, False Claims Act and/or other related laws and regulations can be estimated at this time. The outcome of the ongoing dialogue with the DOJ, as well as an adverse outcome in any future proceedings arising from the physician arrangements at issue, could require a material payment from the System and could negatively impact the operations and/or financial condition of Akron General and/or the System.

UNION HOSPITAL

In December 2017, the Clinic and Union Hospital, located in Dover, Ohio, signed a member substitution agreement for the Clinic through a subsidiary to become the sole corporate member of Union Hospital. The agreement is subject to regulatory approvals and certain conditions that must be completed prior to the closing date, which is expected to be in the second quarter of 2018. Union Hospital has more than 100 patient beds, 300 healthcare providers on staff, and 1,100 employees. It also has several off-campus satellite services and operates a hospital-owned physician network with numerous offices and approximately 20 providers. The Clinic has maintained an existing relationship for the past several years with Union Hospital through the Telestroke Network, which connects patients to the Clinic's Cerebrovascular Center.

FLORIDA GROWTH

In January 2018, Indian River Medical Center (IRMC), located in Southeast Florida, selected the Clinic as its partner to help secure the future of IRMC. On February 22, 2018 the Clinic and IRMC entered into a non-binding letter of intent that outlines plans for a partnership. IRMC is a not-for-profit medical center with over 330 patient beds and is focused on providing healthcare to Indian River and surrounding counties in Florida.

In February 2018, the Clinic and Martin Health System entered into an agreement to explore opportunities for Martin Health System to join the System. Martin Health System is a regional not-for-profit, community-based healthcare provider with three acute-care hospitals and a network of outpatient services. While no timeframe has been set for a decision, the organizations are committed to a careful and thorough review process.

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 System has established a plan to convert the building from office space to an approximately 200-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, which is expected to complete construction in 2020. The facility was fully vacated in the first quarter of 2017.

In addition to the London project, the System operates health and wellness centers in Toronto, Canada, including a sports medicine clinic that was acquired in the fourth quarter of 2017, and provides management services to Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that opened in March 2015 and currently has approximately 364 staffed beds. In 2017, the Clinic has also entered into its first Cleveland

Clinic Connected relationship (its global affiliation program) with an organization planning to open a hospital in Shanghai, China.

These international activities have increased the diversity of the System's healthcare operations while promoting the Clinic's clinical expertise in new markets.

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. Contributing to the reformation of healthcare is a new level of consumerism spurred by the continued growth of high-deductible health insurance products and expectations for transparency, customization, and on-demand solutions. As these changes evolve, the combination of consolidation, a blurring of traditional roles, and new entrants with innovative business models and compelling customer value propositions are reordering the healthcare landscape.

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 national and 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 of caregivers
- Leverage the unique assets and capabilities of the System to grow and extend services to other hospitals and health systems

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, innovation and community health

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 System's highest priorities.

Enterprise priorities for 2018 include the following:

- Improve access to care for patients
- Use of digital technologies to change business models and the delivery of care
- Caregiver engagement
- High reliability through consistently high performance in quality, safety and patient experience
- Population health and management of financial risk for populations of patients
- System development and integration and standardization of operating practices and functions

In 2017, the System launched Cleveland Clinic Community Health, a unit created to better enable healthcare providers and teams to take care of patient populations. Cleveland Clinic Community Health unit is designed to bring primary care providers together under one umbrella — internal medicine, family medicine, hospital medicine, general pediatrics, wellness, home care and Express Care will all report to the same unit. Primary care physicians will be joined by advanced practice providers and medical assistants, who will be supported by nurses, patient service representatives and care coordinators, working together to meet the needs of a specific group, or panel of patients.

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 System is structured to monitor continually its use of resources in all clinical, operational and administrative areas. From 2014 to 2017, management estimates that Care Affordability initiatives and other localized efforts enabled over $860 million of improvements in the cost structure. The System continues to develop and implement cost management and containment plans for a more affordable care model and to enable investments in key strategic initiatives. This work is expected to be an ongoing effort.

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. This is evidenced with the recent launching of co-branded insurance products with payor partners in 2018.

Leadership also is executing a focused growth strategy, domestically and internationally. A

major emphasis of the domestic agenda is focused on hardwiring relationships with selected physician groups and hospitals throughout Northeast Ohio and partnering with community physicians in aligned, yet different, models. The Cleveland Clinic Florida leadership team has begun implementation of a multi-year growth plan that includes expansion of services at current facilities, new ambulatory facilities in surrounding communities and development of clinically integrated networks with other hospitals in South Florida, which has resulted in cascading opportunities for clinical expansion. Meanwhile, leadership continues to execute its international strategy to extend its unique model and capabilities more broadly and to meet its organizational goals through the establishment of new facilities and a network of patient outreach offices located in several countries across the world.

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, organization and delivery of care, effectuation of research and education, and the clearly conveyed message of the organization's value 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

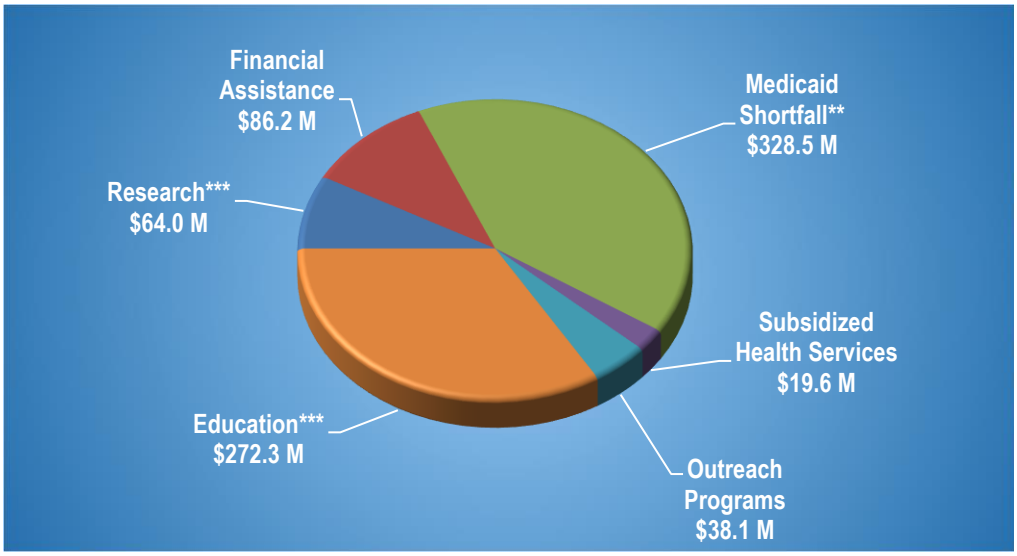
The Clinic and its hospital affiliates within the System are comprised of charitable, tax-exempt healthcare organizations. The System's mission includes addressing health service needs and providing benefits to the communities it serves. The tax-exempt members of the System must satisfy a community benefit standard to maintain their tax-exempt status. Community benefit reporting for the System conforms to Internal Revenue Service (IRS) requirements and is reported on the IRS Form 990, the information return required to be filed annually with the IRS by exempt organizations.

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.

Beachwood Family Health and Surgery Center
Beachwood, Ohio

In 2016, the System provided $808.7 million in benefits to the communities it serves. The following chart summarizes community benefits for the System:

Cleveland Clinic Health System*
Breakdown of Community Benefit (2016)
$808.7 Million



* Includes all System operations in Ohio, Florida and Nevada
** Net of Hospital Care Assurance Program benefit of $3.1 million
*** Research and Education are reported net of externally sponsored funding of $155.0 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 over the last few years, which previously required 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 has been 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 2016.

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, heart disease, cancer and other health conditions. 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.
- Wellness initiatives and community education classes were provided to schools, faith-based organizations and community centers in the areas of prevention, chronic disease management and behavioral change, including smoking cessation, weight management, teen parenting, family violence and child safety.
- Collaborative initiatives with community nonprofits and local governments addressed critical population issues, including the opioid epidemic and infant mortality.
- 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

The System completes comprehensive community health needs assessments (CHNA) once every three years for each hospital. 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 that each 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 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 and have been added to the Clinic's website in compliance with the regulatory requirements.

The current 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 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, 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 2017, the Clinic was awarded the prestigious "Greening the OR" environmental achievement award offered by Practice Greenhealth for the second year in a row. 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 the Top 25 Environmental Excellence Award for Best of Sustainability in Health Care. 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 thirty additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in health care sustainability. In October 2017, the Clinic was awarded the Encouraging Environmental Excellence Award from Ohio Environmental Protection Agency for achievements in environmental stewardship.

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 15% 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 gold certification. Construction projects also emphasize recycling of debris, with current diversion rates of up to 98% in recent years.

The System currently has eighteen 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.

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, consultation, and internally and externally focused pipeline development programs.

In 2017, the System was ranked number five on the list of the country's top twelve healthcare organizations for diversity management practices by DiversityInc. The System has made this list for the eighth 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. Additionally, the Clinic was recognized as a "2017 Leader in LGBTQ Healthcare Equality," by the Human Rights Campaign. This distinction was received by meeting criteria for LGBTQ workforce and patient non-discrimination in policy, training, patient care, and access.

The System's Employee Resource Groups (ERG) have received national recognition and rank among the top 25 ERGs in the country. In 2017 ClinicPride (LGBT) ERG ranked 4th and SALUD (Hispanic/Latino) ERG ranked 24th in a national evaluation of the Association of ERGs and Diversity Councils. This annual national award recognizes, honors, and celebrates the outstanding contribution and achievements of ERGs, business groups, and diversity councils. Additionally in 2017, the System was named one of the Top 50 STEM Workplaces by the American Indian Science and Engineering Society for the fifth consecutive year. In 2018, the System was also recognized in Forbes first ever list of "America's Best Employer's for Diversity," which included 250 employers across various industries.

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 and 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 CONTROL 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 of the System issued a report on the effectiveness of its internal control over financial reporting as part of the issuance of its consolidated financial results for 2017, which is the ninth year the management report was issued. As part of the internal control evaluation process, certifications are completed by 125 members of System 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 control over financial reporting, a step that further increases the transparency of the organization. System management updates the certification on a quarterly basis.

INDUSTRY OUTLOOK

In December 2017, Moody's issued a negative outlook for the U.S. not-for-profit healthcare and hospital sector. Moody's revised its outlook from stable, which it had maintained since August 2015. Moody's expects operating cash flow to contract by 2%-4% over the next 12-18 months. The not-for-profit healthcare sector experienced a larger than expected drop in cash flow in 2017, and there is uncertainty about federal healthcare policy. The negative outlook also reflects Moody's expectation that hospital bad debt will continue to rise. Hospitals are experiencing rising co-pays and high deductibles in health plans, which are increasing bad debt. In February 2018, Moody's stated that it expected not-for-profit hospitals to face a risk of volume declines and margin erosion due to commercial insurers acquiring physician practices. Moody's predicts that insurers will be able to provide preventative, outpatient and post-acute care to their members through these providers at a lower cost than hospitals. Moody's also notes that hospitals are facing pressure from insurers moving to value-based payment options with likely lower rate increases that could result in renegotiation or

termination of contracts between insurers and hospitals. Moody's expects that hospital mergers, acquisitions and affiliations will remain prevalent as an attempt for hospitals to regain leverage with insurers.

In January 2018, S&P maintained its stable outlook for the U.S. not-for-profit healthcare sector. S&P based its rating on the strength of the balance sheets in the sector being close to historical highs, combined with the long-term trend of market consolidation, physician integration and expanded ambulatory presence, which has helped improve the business positions and prospects for many healthcare organizations. S&P does acknowledge that operating risks for some organizations will increase due to changes in the municipal bond market that will increase the cost of capital and recent legislation to eliminate the Affordable Care Act individual mandate, which will likely put financial pressure on hospitals and health systems. S&P stated that the number of downgrades of its rated nonprofit hospitals and health systems exceeded the number of upgrades in 2017 for the first time since 2014 and the number of downgrades is expected to grow in 2018 for organizations already under pressure.

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 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 December 31				For the twelve months ended December 31			
	2017	2016	Variance	%	2017	2016	Variance	%
Inpatient admissions[(1)]								
Acute admissions	41,560	40,804	756	1.9%	169,238	162,930	6,308	3.9%
Post-acute admissions	2,672	3,013	-341	-11.3%	11,710	12,424	-714	-5.7%
	44,232	43,817	415	0.9%	180,948	175,354	5,594	3.2%
Patient days[(1)]								
Acute patient days	217,539	210,183	7,356	3.5%	877,891	846,170	31,721	3.7%
Post-acute patient days	19,392	25,597	-6,205	-24.2%	93,961	103,979	-10,018	-9.6%
	236,931	235,780	1,151	0.5%	971,852	950,149	21,703	2.3%
Surgical cases								
Inpatient	15,131	14,774	357	2.4%	61,529	59,802	1,727	2.9%
Outpatient	35,701	36,996	-1,295	-3.5%	145,825	147,855	-2,030	-1.4%
	50,832	51,770	-938	-1.8%	207,354	207,657	-303	-0.1%
Emergency department visits	158,440	160,301	-1,861	-1.2%	644,575	652,073	-7,498	-1.1%
Observations	14,600	15,112	-512	-3.4%	59,894	58,384	1,510	2.6%
Clinic outpatient evaluation and management visits	1,085,213	1,067,478	17,735	1.7%	4,403,635	4,235,729	167,906	4.0%

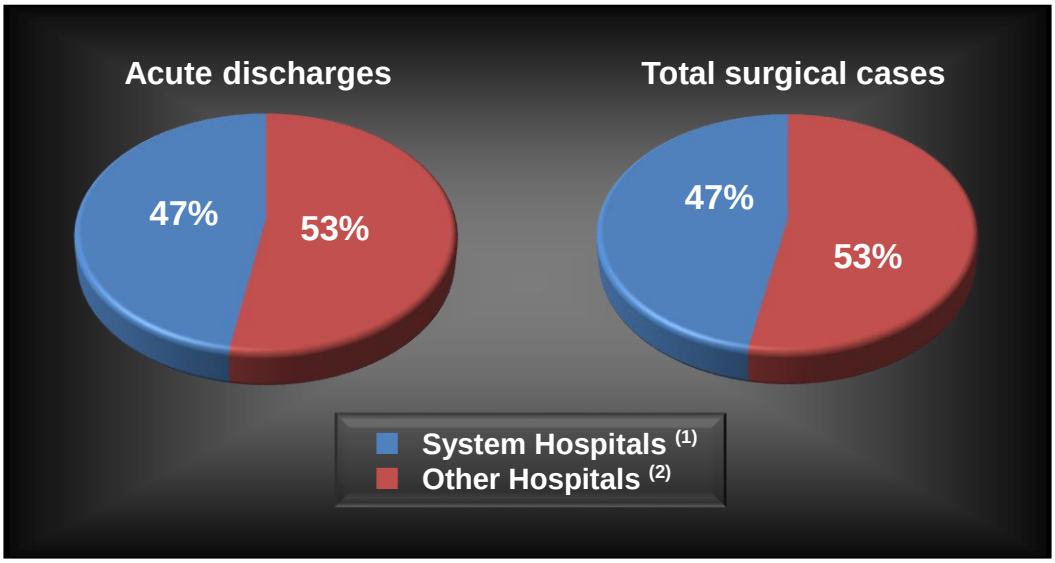
[(1)] Excludes newborns

Inpatient acute admissions for the System increased 2% in the fourth quarter of 2017 and 4% in 2017 compared to 2016. In 2017, the Clinic experienced flat acute admissions, and the regional hospitals, which include Akron General, collectively experienced a 6% increase in acute admissions, which resulted in a 4% increase at the System's facilities in northeast Ohio. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio service area increased 1% in 2017 compared to 2016. The Florida facilities experienced a 3% increase in acute admissions over the same period.

Total surgical cases for the System decreased 2% in the fourth quarter of 2017 and were flat in 2017 compared to 2016. For 2017, total surgical cases decreased 3% at the Clinic's main campus and family health centers and increased 2% at the regional hospitals collectively, which resulted in flat surgical cases at the System's facilities in northeast Ohio compared to the same periods in 2016. According to data from the Center for

Health Affairs, total surgical cases in northeast Ohio increased 2% in 2017 compared to 2016. The Florida facilities remained flat in total surgical cases over the same period. The surgical mix of total surgical cases for the System for 2017 was 30% inpatient and 70% outpatient, which represents an approximately 1% shift from outpatient to inpatient compared to the surgical mix in 2016.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the year ended December 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. Effective April 1, 2017, the System completed the transition of the management of its investment portfolios from a third-party external advisor to the Cleveland Clinic Investment Office (the "CCIO"). These portfolios include the Cleveland Clinic's general long-term investment portfolio, its defined benefit pension fund and the captive insurance fund. Investment professionals in the CCIO are charged with the day-to-day management of these investments and their strategic direction. The System has established formal investment policies that support the System's investment objectives and provide an appropriate balance between return and risk.

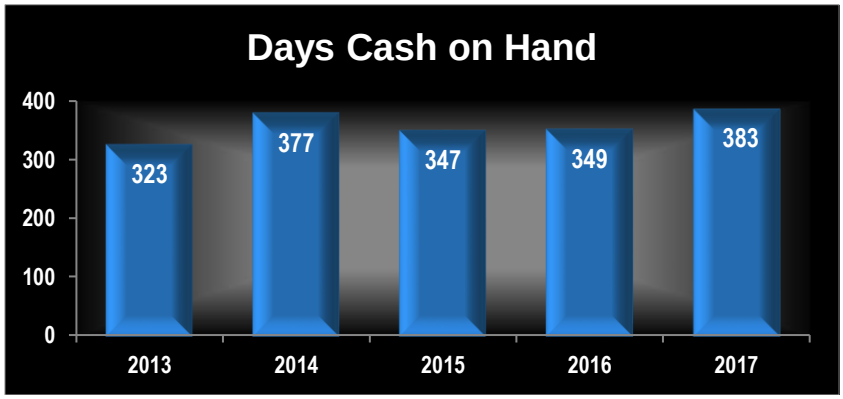
The following table sets forth the allocation of the System's cash and investments at December 31, 2017 and December 31, 2016:

Cash and Investments
(Dollars in thousands)

	December 31, 2017		December 31, 2016	
Cash and cash equivalents	$ 770,654	8%	$ 687,410	9%
Fixed income securities*	2,412,477	27%	2,109,524	27%
Marketable equity securities*	3,192,650	35%	2,785,380	35%
Alternative investments	2,696,560	30%	2,282,940	29%
Total cash and investments	$ 9,072,341	100%	$ 7,865,254	100%
Less restricted investments**	(1,101,417)		(868,367)	
Unrestricted cash and investments	$ 7,970,924		$ 6,996,887	
Days cash on hand	383		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 five years:



At December 31, 2017, total cash and investments for the System (including restricted investments) were $9.1 billion, an increase of $1,207 million from $7.9 billion at December 31, 2016. Cash inflows consist of cash provided by operating activities and related investment income of $1,715 million and a net increase in restricted gifts and income of $182 million. Cash inflows were offset by net capital expenditures of $606 million and scheduled principal payments on debt of $84 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $210.9 million at December 31, 2017, with an asset mix of 23% cash and short-term investments, 36% fixed-income securities, 27% equity investments and 14% alternative investments. The asset mix reflects the need for liquidity and the objective to maintain stable returns utilizing a lower tolerance for risk and volatility consistent with insurance regulatory requirements.

Also included in the System's cash and investments at December 31, 2017 are $173.2 million of funds held by trustees. Bond funds held by trustees totaled $103.9 million and represent deposits with the trustee to fund current principal and interest payments. Funds held by trustees also include $69.2 million of posted collateral related to the System's interest rate swap contracts. The swap 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 December 31, 2017, the asset mix of funds held by trustees was 60% cash and short-term investments and 40% 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 December 31, 2017 and December 31, 2016 consist of the following:

Alternative Investments
(Dollars in thousands)

	December 31, 2017		December 31, 2016	
Hedge funds	$ 1,357,932	50%	$ 1,134,136	50%
Private equity/venture capital	854,632	32%	696,786	30%
Real estate	483,996	18%	452,018	20%
Total alternative investments	$ 2,696,560	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 2.2% for the fourth quarter of 2017, which is lower than the portfolio's benchmark gain of 2.5% and higher than investment losses of 0.1% experienced in the fourth quarter of 2016. For the full year of 2017, the System experienced investment gains of 12.1%, which is higher than the portfolio's benchmark gains of 11.4% and higher than the investment gains of 5.7% experienced for the full year of 2016.

Cleveland Clinic Lou Ruvo Center for Brain Health
Las Vegas, Nevada

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

Investment Return
(Dollars in thousands)

	For the quarter ended December 31		For the year ended December 31	
	2017	2016	2017	2016
Other unrestricted revenue:				
Interest income and dividends	$ 798	$ 612	$ 2,909	$ 2,750
Nonoperating gains and losses, net:				
Interest income and dividends	18,961	18,353	70,135	61,430
Net realized gains on sales of investments	31,078	21,220	177,901	157,358
Net change in unrealized gains (losses) on investments	130,703	(49,913)	518,861	100,079
Equity method income on alternative investments	73,357	52,999	152,178	104,184
Investment management fees	(5,724)	(4,114)	(22,936)	(18,860)
	248,375	38,545	896,139	404,191
Other changes in net assets:				
Investment income on restricted investments and other	16,536	3,849	54,250	24,771
Total investment return	$ 265,709	$ 43,006	$ 953,298	$ 431,712

Pension Investments

In 2015, 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. All benefit accruals for participants in the plan ceased by December 31, 2012. 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 December 31, 2017, the Plan's investments were comprised of 7% cash and cash equivalents, 46% fixed-income investments, 29% equities, and 18% alternative investments.

Cleveland, Ohio Skyline

Long-term Debt

At December 31, 2017, outstanding bonds for the System totaled $3.352 billion, comprised of $2.622 billion (78%) of fixed-rate bonds, $11 million (<1%) of index-rate bonds and $719 million (22%) of variable-rate bonds. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds and certain variable-rate operating lease payments. The total notional amount on the System's interest rate swap contracts at December 31, 2017 was $615 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 $350 million of the variable-rate bonds are secured by irrevocable direct pay letters of credit or standby bond purchase agreements, and another $16 million is directly placed with a financial institution. Bonds 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 would allow the lender to declare an event of default and cause immediate repayment of such bonds are classified as current liabilities.

The remaining $352 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 are supported by the System's self-liquidity program. At December 31, 2017, the System has $71.0 million of outstanding Series 2014A CP Notes.

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

Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	December 31 2017	December 31 2016
2017A	CCHS Obligated Group	Fixed	2043	$ 818,775	$ -
2017B	CCHS Obligated Group	Fixed	2043	169,255	-
2017C	CCHS Obligated Group	Fixed	2032	9,305	-
2016	CCHS Obligated Group	Fixed	2046	325,000	325,000
2016	CCHS Obligated Group	Variable	2026	16,270	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	61,165	63,135
2012A	CCHS Obligated Group	Fixed	2039	451,135	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
2009B	CCHS Obligated Group	Fixed	2039	31,640	366,215
2008A	CCHS Obligated Group	Fixed	2043	7,930	409,740
2008B	CCHS Obligated Group	Variable	2043	327,575	369,250
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
2002	CCHS Obligated Group	Variable	2032	-	9,635
				$ 3,351,555	$ 3,485,140

In August 2017, hospital revenue bonds totaling $988.0 million were issued for the benefit of the System. The proceeds of these bonds were used to refund all or a portion of the outstanding Series 2008A, 2008B, 2009A, 2009B and 2012A Bonds and to pay the cost of issuance.

In December 2017, hospital revenue bonds totaling $9.3 million were issued for the benefit of the System. The proceeds of these bonds were used to refund all of the outstanding Series 2002 Bonds.

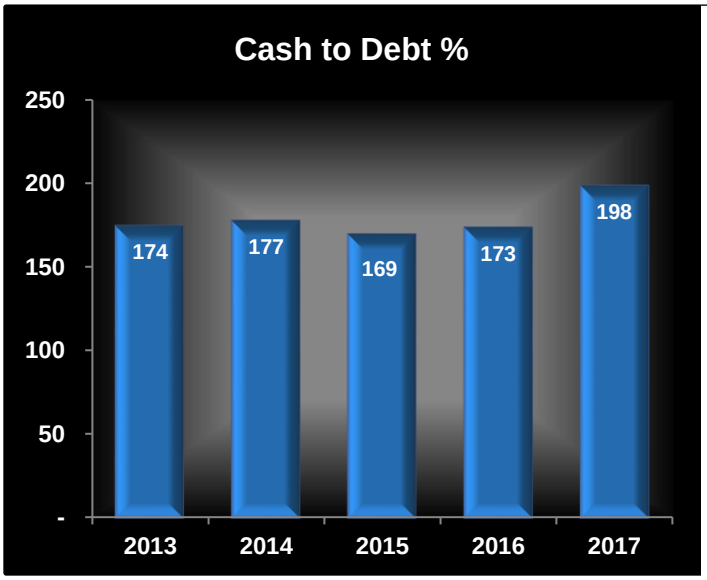
At December 31, 2017, the System has notes payable and capital leases totaling $531.0 million. Notes payable and capital leases include $376.5 million of notes payable, $60 million outstanding on a revolving credit facility and $94.5 million of capital lease liabilities primarily related to property and equipment.

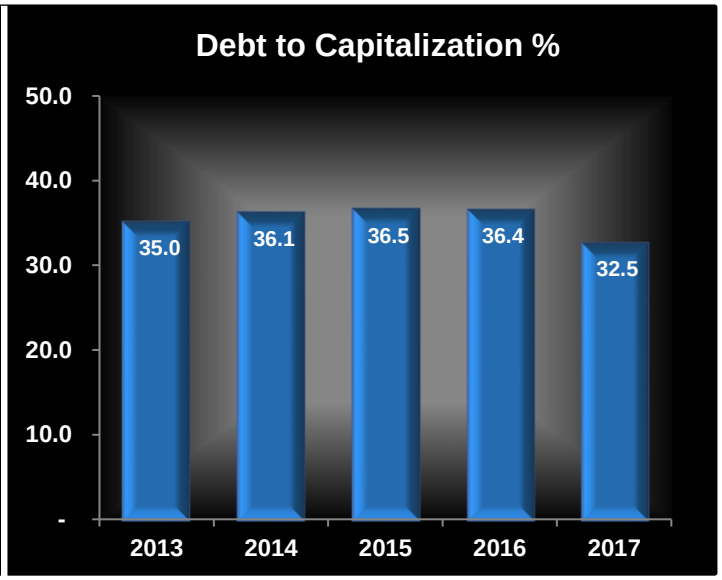
Included in notes payable is a term loan entered into by a Clinic subsidiary with a financial institution in 2015 for a principal amount of $375 million. The proceeds of the term loan were used to finance the System's international business strategy. The term loan matures in 2018 and bears interest at a variable-rate based on the

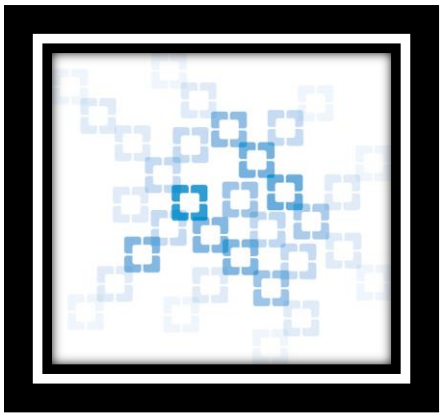
London Interbank Offered Rate (LIBOR) index plus an applicable spread. The Clinic provides a guarantee on the term loan. The term loan is recorded in current portion of long-term debt as of December 31, 2017, and management expects to extend the term loan prior to the maturity date.

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 December 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 five years:







BOND RATINGS

The obligated group's outstanding bonds have been assigned ratings of Aa2 (stable outlook) and AA (stable outlook) by Moody's and S&P, respectively. In August 2017, Moody's affirmed their respective rating and outlook, and S&P raised its rating to AA from AA- and revised the outlook to stable from positive. S&P cites various reasons for the upgrade, including the System's strong governance and management, a very strong enterprise profile and a strong financial profile that is characterized by consistent financial margins and solid liquidity.

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

Bond Ratings

	Rating category		
	Moody's	S&P	Definition
Strongest	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 December 31, 2017 and 2016

Operating income for the System in the fourth quarter of 2017 was $99.7 million, resulting in an operating margin of 4.7%, as compared to operating income of $137.3 million and an operating margin of 6.5% in the fourth quarter of 2016. The lower operating income resulted from a 3.1% increase in operating expenses, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs and supplies. Inpatient volumes were higher in the fourth quarter of 2017 compared to the fourth quarter of 2016, which contributed to a 1.1% increase in total operating revenues. Nonoperating gains for the System were $211.2

million in the fourth quarter of 2017 compared to nonoperating losses of $21.2 million in the fourth quarter of 2016. The increase from the prior year was primarily due overall changes in the financial markets and a favorable variance in actuarial losses related to pension plans that were recorded in each year. Overall, the System reported an excess of revenues over expenses of $310.9 million in the fourth quarter of 2017 compared to an excess of revenues over expenses of $116.1 million in the fourth quarter of 2016.

The System's net patient service revenue increased $1.3 million (0.1%) in the fourth quarter of 2017 compared to the same period in 2016. The System experienced increases in inpatient acute admissions of 1.9% and inpatient surgical cases of 2.4%. Total acute case mix for the System was higher in the fourth quarter of 2017 compared to the same period in 2016, which has resulted in more inpatient revenue per patient. Outpatient evaluation and management visits were 1.7% higher in the fourth quarter of 2017 compared to the same period in 2016, but other outpatient volumes were below the prior year, with decreases in outpatient surgical cases of 3.5%, outpatient observation cases of 3.4% and emergency department visits of 1.2%. The System has also experienced an increase in Medicare and Medicaid revenue primarily as a result of the Affordable Care Act and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 0.7% in the fourth 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 decreased $7.5 million (12.5%) in the fourth quarter of 2017 compared to the same period in 2016. The decrease is primarily attributable to a decrease in self-pay revenue. The System has experienced a shift in revenues into governmental payors. The impact of the shift in payor mix on the provision for uncollectible accounts was partially offset by growth in deductible and copayment balances. The growth in high deductible and copayment 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 $13.5 million (6.5%) in the fourth quarter of 2017 compared to the same period in 2016. The increase in other unrestricted revenues was primarily due to an $8.1 million increase related to gains on the sale of a CCF Innovations spin-off companies and intangible assets related to the Select Medical joint venture, a $5.3 million increase in outpatient pharmacy revenue, a $4.7 million increase in revenue related to a Centers for Medicare and Medicaid Services program

and a $3.5 million increase in management service revenues. These increases were offset by a $2.6 million decrease in rent revenue primarily due to the vacated tenant leases in Grosvenor Place and a $1.6 million decrease in unrestricted gifts and assets released from restriction.

Total operating expenses increased $60.0 million (3.1%) in the fourth 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. 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, wages and benefits increased $20.4 million (1.9%) in the fourth quarter of 2017 compared to the same period in 2016. Salaries, excluding benefits, increased $30.4 million (3.1%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the fourth quarter of 2017 and a 1.3% increase in average full-time equivalent employees in the fourth quarter of 2017 compared to the same period in 2016. Benefit costs decreased $10.0 million (3.2%) during the same period. The System experienced a $10.0 million decrease in employee healthcare costs primarily due to a shift in health care services from external providers to providers within the System and a $5.7 million decrease in long-term disability costs. These decreases were offset by a $2.1 million increase in FICA expenses primarily due to the increase in salaries and full-time equivalent employees.

Supplies expense increased $14.0 million (7.3%) in the fourth quarter of 2017 compared to the same period in 2016. The System experienced a $13.6 million increase in implantables and other medical supplies primarily due to higher surgical volumes and a $0.4 million increase in non-medical supplies.

Pharmaceutical costs increased $21.7 million (9.6%) in the fourth 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 fourth 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 $10.0 million (7.7%) in the fourth quarter of 2017 compared to the same period in 2016. The System experienced an $8.2 million decrease in purchased medical services primarily related to external lab services and Medicare ACO expenses and an $18.2 million net increase in purchased non-medical service costs primarily related to various costs associated with certain System projects and initiatives. Included in the net increase in purchased non-medical costs is a $6.2 million decrease in expense to adjust deferred tax liabilities based on new corporate tax rates.

Administrative services increased $5.8 million (10.2%) in the fourth quarter of 2017 compared to the same period in 2016. The increase in

administrative services was primarily due to a $5.5 increase in consulting fees and professional services for certain System projects and initiatives.

Facilities expense decreased $4.8 million (5.5%) in the fourth quarter of 2017 compared to the same period in 2016. The decrease in facilities expense was primarily due to a $4.0 million decrease in facility costs associated with 33 Grosvenor Place as the building was vacated in early 2017 and a $3.0 million decrease in rent expenses due to the expiration of various operating leases. These decreases were offset by a $1.3 million in repairs and maintenance costs.

Insurance expense increased $2.8 million (25.5%) in the fourth 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 related to the timing of recording favorable developments of outstanding prior year claims. The System experienced favorable developments in both 2017 and 2016. However, the amount recorded in the fourth quarter of 2016 was greater than the amount recorded in the fourth quarter of 2017. 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 decreased $3.3 million (9.1%) in the fourth quarter of 2017 compared to the same period in 2016. The decrease is primarily due to $84.3 million of principal payments on bonds, notes and capital leases in 2017 and the issuance of the Series 2017A Bonds and the Series 2017B Bonds in the third quarter of 2017 that refunded $1.1 billion of fixed-rate bonds at a lower interest rate.

Depreciation and amortization expenses decreased $4.9 million (4.0%) in the fourth 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 $1.7 million (60.8%) in the fourth quarter of 2017 compared to the same period in 2016. The System incurred and recorded $1.1 million and $2.8 million of special charges in the fourth quarters of 2017 and 2016, respectively. Special charges in the fourth quarter of 2017 and 2016 include $1.0 million and $2.6 million, respectively, 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 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. Special charges in the fourth quarter of 2016 also include $0.2 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place. The System is converting the building from office space to a healthcare facility.

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 $211.2 million in the fourth quarter of 2017 compared to a net loss of $21.2 million in the fourth quarter of 2016, resulting in a favorable variance of $232.4 million. Investment returns were favorable by $209.8 million in the fourth quarter of 2017 compared to the same period in 2016. The System's long-term investment portfolio reported investment gains of 2.2% for the fourth quarter of 2017, which is lower than the portfolio's benchmark gain of 2.5% but higher than investment gains of 0.1% experienced in the fourth quarter of 2016. Derivative losses were unfavorable by $40.6 million in the fourth 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 $63.2 million favorable variance in other nonoperating gains primarily related to net periodic pension benefit costs. The System adopted Accounting Standard Update 2017-07 on January 1, 2017, which requires the System to record all components of net periodic benefit cost except service cost in nonoperating gains and losses. Net periodic benefits costs reported in other nonoperating gains and losses were favorable by $71.8 million in 2017, compared to 2016, primarily due to lower actuarial losses recognized by the defined benefit and other postretirement benefit plans. The System also experienced a $2.0 million favorable variance in foreign currency transaction gains and losses primarily due to the remeasurement of assets and liabilities from the British Pound to the U.S. Dollar.

For the Years Ended December 31, 2017 and 2016

Operating income for the System in 2017 was $330.6 million, resulting in an operating margin of 3.9%, as compared to operating income of $243.2 million and an operating margin of 3.0% in 2016. The higher operating income resulted from a 4.6% increase in total unrestricted revenues, which was primarily due to strong patient volumes and a non-patient payment received from a payor in the second quarter of 2017. Operating expenses increased 3.6% in 2017 compared to the same period of 2016, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs and supplies. Nonoperating gains for the System were $819.8 million in 2017 compared to nonoperating gains of $270.3 million in 2016. The increase from the prior year was primarily due to gains on investments attributable to overall changes in the financial markets and a favorable variance in net periodic benefit cost reported in nonoperating gains and losses. Overall, the System reported an excess of revenues over expenses of $1,150.3 million in 2017 compared to an excess of revenues over expenses of $513.5 million in 2016.

The System's net patient service revenue increased $243.5 million (3.2%) in 2017 compared to 2016. The System experienced increases in inpatient acute admissions of 3.9% and outpatient evaluation and management visits of 4.0% in 2017 compared to 2016. Total surgical cases were flat in 2017 compared to 2016, with inpatient surgical cases increasing 2.9% and outpatient surgical cases decreasing 1.4%. Total acute case mix for the System was higher in 2017 compared to 2016, which has resulted in more inpatient revenue per patient. The System

has experienced an increase in Medicare and Medicaid revenue primarily as a result of the Affordable Care Act and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 0.9% in 2017 compared to 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 and the opening of Avon Hospital in November 2016. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts decreased $5.2 million (1.7%) in 2017 compared to 2016. The decrease is primarily attributable to the decrease in self-pay revenues. Self-pay revenues for the System were 2.2% of total gross patient revenues in 2017, which is lower than 2.5% experienced in 2016. Offsetting the impact of lower self-pay revenues on provision for uncollectible accounts was an increase in deductible and copayment balances. The growth in high deductible and copayment 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 $121.1 million (15.4%) in 2017 compared to 2016. The increase in other unrestricted revenues was primarily due to a $70.0 million non-patient payment received from a payor in the second quarter of 2017, a $24.9 million increase in outpatient pharmacy revenue, a $14.4 million increase in management service contract revenue, a $13.8 million increase in revenue related to a Centers for Medicare and Medicaid Services program, a $11.2 million increase related to gains on the sale of two Cleveland Clinic Innovations spin-off companies and a gain on the sale of intangible assets related to the Select Medical joint venture, a $6.5 million increase in revenue related to research grants and a $2.6 million increase in equity earnings on joint venture investments with Select Medical. These increases were offset by a $14.6 million decrease in rent revenue primarily due to the vacated tenant leases in Grosvenor Place and an $8.7 million decrease in unrestricted gifts and assets released from restriction.

Total operating expenses increased $282.5 million (3.6%) in 2017 compared to 2016. Notable increases in expenses were experienced in salaries, wages and benefits, pharmaceutical costs and supplies, which are 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, wages and benefits increased $134.2 million (3.0%) in 2017 compared to 2016. Salaries and wages, excluding benefits, increased $140.2 million (3.7%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2017 and a 2.1% increase in average full-time equivalent employees in 2017 compared to 2016. Benefit costs decreased $6.1 million (1.0%) during the same period. The decrease in benefit costs was primarily due to a $12.5 million decrease in employee healthcare costs due to a shift in health care services from external providers to providers within the System, a $7.3 million decrease in long-term disability costs driven by claim terminations and social security approvals, a $2.0 million decrease in service cost on the System's defined benefit pension plans and a $1.8 million decrease in workers compensation costs. These decreases were offset by an $11.0 million increase in FICA expenses and a $6.8 million increase in defined contribution plan expenses primarily due to the increase in salaries and full-time equivalent employees.

Supplies expense increased $44.3 million (5.9%) in 2017 compared to 2016. The System experienced a $41.1 million increase in implantables and other medical supplies primarily due to higher surgical volumes and a $3.2 million increase in non-medical supplies.

Pharmaceutical costs increased $94.3 million (10.9%) in 2017 compared to 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 $19.7 million in 2017 compared to 2016. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $26.9 million (5.3%) in 2017 compared to 2016. The increase in purchased service expenses was due to a $7.8 million decrease in purchased medical services primarily related to external lab services and Medicare ACO expenses and a $34.7 million net increase in purchased non-medical service costs, which includes a $6.2 million increase in software and hardware technology agreements, a $4.7 million increase in state franchise fee expenses and a $6.2 million decrease in expense to adjust deferred tax liabilities based on new corporate tax rates. The System also experienced an increase in various purchased non-medical service costs related to certain System projects and initiatives.

Administrative services increased $1.9 million (1.0%) in 2017 compared to 2016. The increase in administrative services was primarily due to a $6.3 million increase in travel and education expenses driven by travel expenses related to the System's expanding international strategy offset by a $1.2 million decrease in expenses related to research projects.

Facilities expense decreased $9.0 million (2.6%) in 2017 compared to 2016. The decrease in facilities expense was primarily due to a $7.4 million decrease in rent expenses due to the expiration of various operating leases and a $2.1 million decrease in facility costs associated with 33 Grosvenor Place as the building was vacated in early 2017. These decreases were offset by a $0.5 million increase in repairs and maintenance costs.

Insurance expense decreased $5.7 million (8.5%) in 2017 compared to 2016. The decrease in insurance expense was primarily due to a decrease in professional malpractice expense due to favorable development of outstanding prior year claims. The System recorded a $1.4 million decrease in unasserted claim liabilities in 2017 and a $1.7 million increase in unasserted claim liabilities in 2016, resulting in a $3.1 million reduction in insurance expense in 2017 compared to 2016. 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 $4.7 million (3.5%) in 2017 compared to 2016. The System has experienced higher interest rates on its variable-rate bonds and notes payable in 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 $84.3 million of principal payments on bonds, notes and capital leases in 2017 and the issuance of the Series 2017A Bonds and the Series 2017B Bonds in the third quarter of 2017 that refunded $1.1 billion of fixed-rate bonds at a lower interest rate.

Depreciation and amortization expenses increased $10.9 million (2.3%) in 2017 compared to 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 $20.1 million (78.6%) in 2017 compared to 2016. The System incurred and recorded $5.5 million and $25.6 million of special charges in 2017 and 2016, respectively. Special charges in 2017 and 2016 include $5.5 million and $17.8 million, respectively, 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 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. Special charges in 2016 also includes $7.8 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place. The System is converting the building from office space to a healthcare facility.

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 $819.8 million in 2017 compared to a net gain of $270.3 million in 2016, resulting in a favorable variance of $549.5 million. Investment returns were favorable by $491.9 million in 2017 compared to 2016. The System's long-term investment portfolio reported investment gains of 12.1% for 2017, which is higher than the portfolio's benchmark gain of 11.4% and higher than investment gains of 5.7% experienced in 2016. Derivative losses were favorable by $20.5 million in 2017 compared to 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 $37.0 million favorable variance in other nonoperating gains and losses primarily related to net periodic benefit costs, losses on extinguishment of debt and foreign currency transaction gains and losses. The System adopted Accounting Standard Update 2017-07 on January 1, 2017, which requires the System to record all components of net periodic benefit cost except service cost in nonoperating gains and losses. Net periodic benefits costs reported in other nonoperating gains and losses were favorable by $80.4 million in 2017, compared to 2016, primarily due to lower actuarial losses recognized by the defined benefit and other postretirement benefit plans. The System recorded a $46.2 million and $3.9 million loss on extinguishment of debt in 2017 and 2016, respectively, related to bonds that were refunded or redeemed in each period. Foreign currency transaction gains and losses were favorable by $8.6 million in 2017 compared to 2016 primarily due to the remeasurement of assets and liabilities from the British Pound to the U.S. Dollar.

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

Patient accounts receivable, net of allowances for uncollectible accounts, decreased $46.3 million (4.4%) from December 31, 2016 to December 31, 2017. The decrease in patient receivables is partially due to cash collection efforts and other initiatives to reduce patient receivable balances and create efficiencies in the revenue cycle process, including the implementation of EAPM. EAPM was implemented at the Clinic in 2016. Medina Hospital and Marymount Hospital implemented EAPM in the second quarter of 2017, and Akron General Medical Center and Lodi Hospital implemented EAPM in the third quarter of 2017. The Clinic made significant improvements in the timely billing and collection of patient revenue that has reduced patient accounts receivable in 2017. The System records estimated allowances that result in patient accounts receivable being reported at the net amount expected to be received. The System has experienced an increase 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. Days revenue outstanding for the System decreased from 51 days at December 31, 2016 to 49 days at December 31, 2017.

Investments for current use increased $102.8 million (197.3%) from December 31, 2016 to December 31, 2017. Investments for current use includes funds held by the bond trustee that will be used to pay current debt service payments. The System funded $103.9 million to the bond trustee in 2017 to fund debt service payments that will occur in 2018. There were no funds held by the bond trustee reported in investment for current use at December 31, 2016. Investments for current use also includes assets held for self-insurance that will be used to pay the current portion of estimated claim liabilities. These investments decreased $1.1 million due to reclassifications of investments from current to long-term.

Other current assets decreased $22.2 million (5.6%) from December 31, 2016 to December 31, 2017. The decrease in other current assets was primarily due to a $12.5 million decrease in current pledge receivables and a $31.8 million decrease in receivables related to the timing of receipts for various Medicare and Medicaid programs, including reductions in Medicare ACO receivables, prior year cost report receivables related to the Weston graduate medical education program, Hospital Care Assurance Program receivables and electronic health record incentive receivables. These decreases were offset by a $10.4 million increase in inventories primarily related to pharmaceuticals and a $4.0 million increase in prepaid expenses driven by annual maintenance contracts.

Unrestricted long-term investments increased $1.3 billion (19.4%) from December 31, 2016 to December 31, 2017. The increase was primarily due to positive unrestricted investment returns and cash flow from operations and includes transfers of cash and cash equivalents form short-term operating cash to unrestricted long-term investments. Total unrestricted cash, cash equivalents and long-term investments increased $974.0 million from December 31, 2016 to December 31, 2017. The System experienced $1,714.5 million of net positive cash flow from operations and investment income in 2017, which was partially offset by net capital expenditures of $606.2 million and principal payments on long-term debt of $84.3 million. Investment return on the System's long-term investment portfolio was 12.1% in 2017.

Funds held by trustees decreased $6.7 million (8.8%) from December 31, 2016 to December 31, 2017. The decrease in funds held by trustees is primarily due to a $6.4 million decrease in collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance increased $31.7 million (24.7%) from December 31, 2016 to December 31, 2017. The increase in self-insurance assets is primarily due to investment gains experienced in the System's captive insurance subsidiary and premiums received by the captive insurance subsidiary in excess of reimbursement payments for claims previously settled and paid by other System entities.

Donor restricted assets increased $105.2 million (17.2%) from December 31, 2016 to December 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 increased $187.6 million (4.2%) from December 31, 2016 to December 31, 2017. The System had net expenditures for property, plant and equipment of $606.2 million, offset by depreciation expense of $488.9 million, which includes $3.4 million of accelerated depreciation expense recorded in special charges. Increases in PPE also resulted from $28.4 million of foreign currency translation gains. Capital expenditures in 2017 include amounts paid on retainage liabilities recorded at December 31, 2016 and exclude assets acquired through capital leases and other financing arrangements. Retainage liabilities increased $13.9 million and new capital leases and other financing arrangements totaled $28.1 million in 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 description of many of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets increased $78.7 million (12.5%) from December 31, 2016 to December 31, 2017. The increase in noncurrent assets was primarily due to a $57.3 million increase in receivables related to joint fundraising efforts by the Clinic and CWRU for the health education campus that has a corresponding offsetting noncurrent liability, a $43.3 million increase in deferred compensation plan assets, a $10.9 million increase in goodwill primarily related to a physicians practice acquisition in 2017, a $8.4 million increase in the value of perpetual and charitable trusts and a $5.0 million increase in interests in foundations. These increases were offset by a $48.8 million decrease in donated property assets that were liquidated in the second quarter of 2017. The Clinic received the donated property in prior years to fulfill a pledge receivable.

Accounts payable increased $21.3 million (4.4%) from December 31, 2016 to December 31, 2017. The increase in accounts payable was primarily attributable to the timing of payment processing for trade payables, a $13.9 million increase in retainage liabilities on current construction projects and a $6.5 million increase in outstanding checks.

Compensation and amounts withheld from payroll increased $23.0 million (7.1%) from December 31, 2016 to December 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 $376.1 million (>100%) from December 31, 2016 to December 31, 2017. The System reclassified a $375 million term loan that matures in the second quarter of 2018 from long-term to current. The term loan was executed in 2015 to fund the System's international business strategy. The System expects to refinance the term loan prior to its maturity date. The System also reclassified other regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments of $84.3 million made in 2017.

Variable rate debt classified as current increased $46.2 million (8.8%) from December 31, 2016 to December 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 increase in variable rate debt classified as current is primarily due to the reclassification of $88.0 million from long-term to current related to a subseries of the Series 2008B Bonds supported by a standby bond purchase agreement that expires within one year. The System expects the standby bond purchase agreement to be extended prior to its maturity date. This increase was offset by the redemption of $39.7 million of bonds classified as variable rate debt classified as current in connection with the issuance of bonds in 2017 and a $2.1 million reclassification from variable rate debt classified as current to current portion of long-term debt for regularly scheduled principal payments.

Other current liabilities decreased $23.9 million (5.2%) from December 31, 2016 to December 31, 2017. The decrease in other current liabilities is primarily due to a $11.9 million decrease in accrued interest payable related to bonds that pay interest semi-annually in January and July of each year, an $11.1 million decrease in the fair value of the System's foreign exchange derivative contracts, a 5.2 million decrease in the current portion of employee benefit related liabilities and a $4.9 million decrease in third-party liabilities. These decreases were offset by

a $15.2 million increase in pledges payable primarily due to a reclassification from long-term to current for pledge payments in connection with the transition of health care services in the City of Lakewood.

Hospital revenue bonds decreased $65.5 million (2.2%) from December 31, 2016 to December 31, 2017. The decrease is primarily due to the reclassification of bonds from long-term to variable debt rate classified as current and the reclassification of regularly scheduled principal payments from long-term to current for bond payments due within one year. The issuance of bonds in 2017 advance refunded approximately $1.1 billion of various bond series.

Notes payable and capital leases decreased $381.9 million (73.9%) from December 31, 2016 to December 31, 2017. The decrease is primarily due to the reclassification of a $375 million term loan that matures in the second quarter of 2018 from long-term to current. The System also reclassified other regularly scheduled principal payments from long-term to current, offset by $16.2 million in new capital leases recorded in 2017.

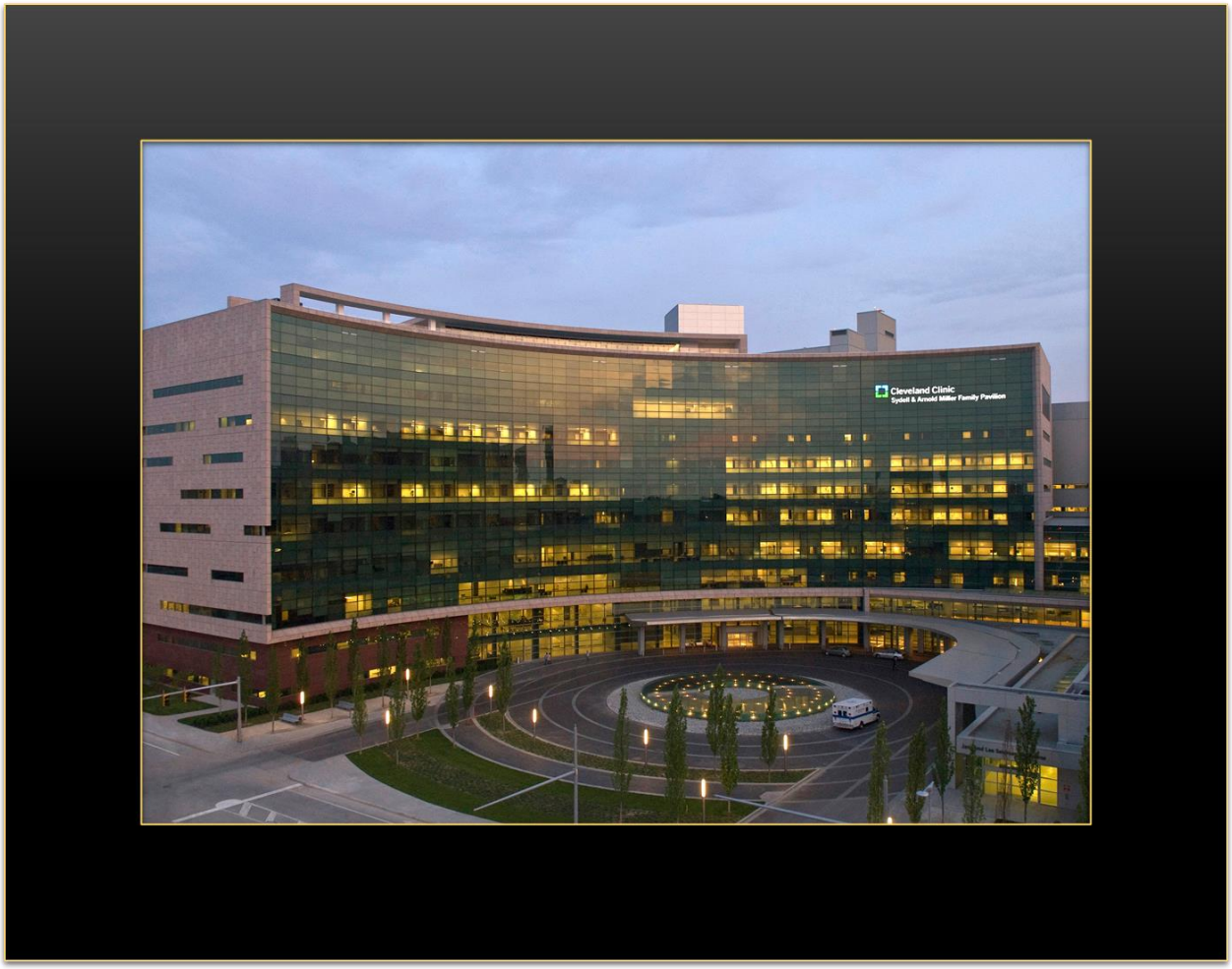
Professional and general insurance liability reserves increased $1.2 million (0.8%) from December 31, 2016 to December 31, 2017. The increase is due to expenses recorded for the accrual of current year claim estimates in excess of claim liability payments and the reclassification of $1.1 million of liability reserves from current to long-term.

Accrued retirement benefits increased $14.0 million (2.9%) from December 31, 2016 to December 31, 2017. The change in accrued retirement benefits is comprised of a $17.0 million increase in the System's defined benefit pension plan liabilities and a $3.0 million decrease in other postretirement benefit liabilities. The increase in defined benefit pension plan liabilities was primarily due to $26.4 of net periodic benefit cost, which includes the recognition of $33.5 million of actuarial losses in excess of the corridor, which is 10% of the greater of the projected benefit obligation or the fair value of the plan assets, a $7.6 million settlement charge, a $2.1 million retirement benefits adjustment for amounts recorded in unrestricted net assets and a $0.4 million reclassification of liabilities from current to long-term, offset by $11.9 million of employer contributions. The recognition of actuarial losses in net periodic benefit cost for the defined benefit plans resulted from a decrease in the discount rate used to determine the benefit obligation. The decrease in other postretirement liabilities was comprised of $4.2 million in employer contributions and a reduction for net periodic benefit credit of $1.4 million, offset by $1.3 million in retirement benefit adjustments recorded in unrestricted net assets, a $0.9 million federal subsidy on benefits paid and $0.4 million reclassification from current to long-term.

Other noncurrent liabilities increased $92.2 million (8.3%) from December 31, 2016 to December 31, 2017. The increase in other noncurrent liabilities is primarily due to a $57.3 million increase in liabilities related to joint fundraising efforts by the Clinic and CWRU for the health education campus that has a corresponding offsetting noncurrent asset, a $40.1 million increase in employee benefit related liabilities and a $10.9 million increase in financing liabilities for joint venture construction projects. These increases were offset by a $15.4 million decrease in derivative liabilities associated with changes in the fair value of the System's interest rate swap derivative contracts, a $13.8 million reclassification of pledges payable from long-term to current and a $5.9 million decrease in third-party liabilities.

Total net assets increased $1.3 billion (16.4%) from December 31, 2016 to December 31, 2017.

Unrestricted net assets increased $1.3 billion (17.8%) primarily due to an excess of revenues over expenses of $1.2 billion, assets released from restriction for capital purposes of $81.9 million and foreign currency translation gains of $29.3 million. Temporarily restricted net assets increased $34.8 million (5.5%), primarily due to $98.6 million in temporarily restricted gifts and $55.1 million in net investment income offset by $123.5 million in assets released from restrictions for operations and capital purposes. Permanently restricted net assets increased $24.5 million (7.9%) primarily due to $22.1 million of permanently restricted gifts and a $2.3 million increase in the value of perpetual trusts.



Cleveland Clinic Main Campus
Sydell & Arnold Miller Family Pavilion
Cleveland, Ohio

FORWARD-LOOKING STATEMENTS

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

- Changes to the Medicare and Medicaid reimbursement systems resulting in reductions in payments and/or changes in eligibility of patients to qualify for Medicare and Medicaid;
- Legislative reforms or actions that reduce the payment for, and/or utilization of, healthcare services, such as the Patient Protection and Affordable Care Act and/or draft legislation to address reimbursement cuts related to the Sustainable Growth Rate Formulas;
- Possible repeal and/or replacement of the Patient Protection and Affordable Care Act, and repeal of the individual mandate;
- Adjustments resulting from Medicare and Medicaid reimbursement audits, including audits initiated by the Medicare Recovery Audit Contractor program;
- Future contract negotiations between public and private insurers, employers and participating hospitals, including the System's hospitals, and other efforts by these insurers and employers to limit hospitalization costs and coverage;
- 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 and state laws on tax-exempt organizations relating to exemption from income taxes, sales taxes, real estate taxes, excise taxes and bond financing, including the Tax Cuts and Jobs Act;
- 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.