Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended June 30, 2018

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	June 30 2018	December 31 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 259,817	$ 241,227
Patient receivables, net	1,109,399	1,012,903
Investments for current use	51,051	154,971
Other current assets	399,779	374,726
Total current assets	1,820,046	1,783,827
Investments:		
Long-term investments	7,774,761	7,729,697
Funds held by trustees	49,412	69,234
Assets held for self-insurance	112,996	159,802
Donor restricted assets	732,913	717,410
	8,670,082	8,676,143
Property, plant, and equipment, net	4,830,091	4,699,697
Other assets:		
Pledges receivable, net	155,894	151,019
Trusts and interests in foundations	94,073	80,643
Other noncurrent assets	444,756	475,010
	694,723	706,672
Total assets	$ 16,014,942	$ 15,866,339

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	June 30 2018	December 31 2017
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 449,307	$ 503,691
Compensation and amounts withheld from payroll	393,580	345,446
Current portion of long-term debt	460,103	457,813
Variable rate debt classified as current	497,820	573,270
Other current liabilities	444,999	438,662
Total current liabilities	2,245,809	2,318,882
Long-term debt:		
Hospital revenue bonds	2,871,934	2,861,438
Notes payable and capital leases	174,312	134,840
	3,046,246	2,996,278
Other liabilities:		
Professional and general insurance liability reserves	140,772	147,327
Accrued retirement benefits	484,149	492,833
Other noncurrent liabilities	541,650	567,566
	1,166,571	1,207,726
Total liabilities	6,458,626	6,522,886
Net assets:		
Unrestricted	8,523,251	8,346,649
Temporarily restricted	677,235	662,189
Permanently restricted	355,830	334,615
Total net assets	9,556,316	9,343,453
Total liabilities and net assets	$ 16,014,942	$ 15,866,339

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended June 30	
	2018	2017
Unrestricted revenues		
Net patient service revenue before provision for uncollectible accounts		$1,963,274
Provision for uncollectible accounts		(82,715)
Net patient service revenue	$1,987,206	1,880,559
Other	221,036	283,898
Total unrestricted revenues	2,208,242	2,164,457
Expenses		
Salaries, wages, and benefits	1,225,495	1,158,304
Supplies	213,842	199,424
Pharmaceuticals	272,344	234,411
Purchased services and other fees	142,493	133,573
Administrative services	56,052	48,743
Facilities	89,323	79,187
Insurance	22,447	20,675
	2,021,996	1,874,317
Operating income before interest, depreciation, and amortization expenses	186,246	290,140
Interest	34,489	35,711
Depreciation and amortization	125,702	122,545
Operating income before special charges	26,055	131,884
Special charges	954	1,426
Operating income	25,101	130,458
Nonoperating gains and losses		
Investment return	(831)	173,453
Derivative gains (losses)	5,691	(6,239)
Other, net	50,750	5,607
Net nonoperating gains and losses	55,610	172,821
Excess of revenues over expenses	80,711	303,279

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Total net assets at April 1, 2017	$ 7,399,938	$ 656,524	$ 314,815	$ 8,371,277
Excess of revenues over expenses	303,279	-	-	303,279
Donated capital and assets released from restrictions for capital purposes	67,799	(67,799)	-	-
Gifts and bequests	-	19,836	1,748	21,584
Transfer of net assets	251	(251)	-	-
Net investment income	-	10,195	-	10,195
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(8,767)	-	(8,767)
Retirement benefits adjustment	(659)	-	-	(659)
Change in interests in foundations	-	3,162	-	3,162
Change in value of perpetual trusts	-	-	499	499
Foreign currrency translation	12,880	-	-	12,880
Net change in unrealized gains on nontrading investments	403	-	-	403
Other	201	-	-	201
Increase (decrease) in net assets	384,154	(43,624)	2,247	342,777
Total net assets at June 30, 2017	$ 7,784,092	$ 612,900	$ 317,062	$ 8,714,054
Total net assets at April 1, 2018	$ 8,466,053	$ 670,775	$ 338,009	$ 9,474,837
Excess of revenues over expenses	80,711	-	-	80,711
Donated capital and assets released from restrictions for capital purposes	929	(469)	-	460
Gifts and bequests	-	16,556	4,657	21,213
Transfer of net assets	(83)	83	-	-
Net investment income	-	1	-	1
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(9,941)	-	(9,941)
Retirement benefits adjustment	(717)	-	-	(717)
Change in interests in foundations	-	(54)	-	(54)
Change in value of perpetual trusts	-	-	268	268
Foreign currrency translation	(22,846)	-	-	(22,846)
Member substitution contribution	-	284	12,896	13,180
Other	(796)	-	-	(796)
Increase in net assets	57,198	6,460	17,821	81,479
Total net assets at June 30, 2018	$ 8,523,251	$ 677,235	$ 355,830	$ 9,556,316

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Six Months Ended June 30	
	2018	2017
Unrestricted revenues		
Net patient service revenue before provision for uncollectible accounts		$ 3,921,653
Provision for uncollectible accounts		(171,811)
Net patient service revenue	$ 3,896,980	3,749,842
Other	433,713	483,518
Total unrestricted revenues	4,330,693	4,233,360
Expenses		
Salaries, wages, and benefits	2,408,715	2,315,541
Supplies	417,041	393,049
Pharmaceuticals	526,569	458,076
Purchased services and other fees	270,753	259,699
Administrative services	96,029	92,794
Facilities	174,553	162,564
Insurance	42,321	40,824
	3,935,981	3,722,547
Operating income before interest, depreciation, and amortization expenses	394,712	510,813
Interest	67,490	71,884
Depreciation and amortization	252,757	244,374
Operating income before special charges	74,465	194,555
Special charges	1,788	3,384
Operating income	72,677	191,171
Nonoperating gains and losses		
Investment return	36,273	416,135
Derivative gains (losses)	21,107	(4,183)
Other, net	57,126	8,719
Net nonoperating gains and losses	114,506	420,671
Excess of revenues over expenses	187,183	611,842

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at January 1, 2017	$7,088,209	$ 627,426	$ 310,164	$ 8,025,799
Excess of revenues over expenses	611,842	-	-	611,842
Donated capital and assets released from restrictions for capital purposes	68,706	(68,706)	-	-
Gifts and bequests	-	43,333	5,854	49,187
Transfer of net assets	251	(251)	-	-
Net investment income	-	24,597	-	24,597
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(16,661)	-	(16,661)
Retirement benefits adjustment	(1,317)	-	-	(1,317)
Change in interests in foundations	-	3,162	-	3,162
Change in value of perpetual trusts	-	-	1,044	1,044
Foreign currency translation	16,553	-	-	16,553
Net change in unrealized losses on nontrading investments	(430)	-	-	(430)
Other	278	-	-	278
Increase (decrease) in net assets	695,883	(14,526)	6,898	688,255
Balances at June 30, 2017	$7,784,092	$ 612,900	$ 317,062	$ 8,714,054
Balances at January 1, 2018	$8,346,649	$ 662,189	$ 334,615	$ 9,343,453
Excess of revenues over expenses	187,183	-	-	187,183
Donated capital and assets released from restrictions for capital purposes	1,526	(1,066)	-	460
Gifts and bequests	-	39,001	7,421	46,422
Transfer of net assets	(72)	72	-	-
Net investment income	-	201	-	201
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(23,392)	-	(23,392)
Retirement benefits adjustment	(1,432)	-	-	(1,432)
Change in interests in foundations	-	(54)	-	(54)
Change in value of perpetual trusts	-	-	898	898
Foreign currency translation	(9,846)	-	-	(9,846)
Member substitution contribution	-	284	12,896	13,180
Other	(757)	-	-	(757)
Increase in net assets	176,602	15,046	21,215	212,863
Balances at June 30, 2018	$8,523,251	$ 677,235	$ 355,830	$ 9,556,316

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Six Months Ended June 30	
	2018	2017
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 212,863	$ 688,255
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Retirement benefits adjustment	1,432	1,317
Net realized and unrealized gains on investments	(11,280)	(416,111)
Depreciation and amortization	254,352	246,163
Provision for uncollectible accounts	-	171,811
Foreign currency translation loss (gain)	9,846	(16,553)
Donated capital	(460)	-
Restricted gifts, bequests, investment income, and other	(47,467)	(77,990)
Accreted interest and amortization of bond premiums	(3,055)	(733)
Net gain in value of derivatives	(29,658)	(12,773)
Member substitution contribution	(65,442)	-
Changes in operating assets and liabilities:		
Patient receivables	(75,589)	(136,220)
Other current assets	(19,819)	(15,796)
Other noncurrent assets	33,576	46,003
Accounts payable and other current liabilities	3,916	(51,088)
Other liabilities	(15,741)	(4,949)
Net cash provided by operating activities and net nonoperating gains and losses	247,474	421,336
Financing activities		
Proceeds from long-term borrowings	45,000	-
Principal payments on long-term debt	(117,373)	(71,106)
Change in pledges receivables, trusts and interests in foundations	(6,533)	(9,697)
Restricted gifts, bequests, investment income, and other	47,467	77,990
Net cash used in financing activities	(31,439)	(2,813)
Investing activities		
Expenditures for property and equipment, net	(356,631)	(263,830)
Net change in cash equivalents reported in long-term investments	252,518	(163,799)
Purchases of investments	(1,255,992)	(1,233,511)
Sales of investments	1,163,279	1,298,932
Member substitution cash contribution	1,515	-
Net cash used in investing activities	(195,311)	(362,208)
Effect of exchange rate changes on cash	(2,134)	854
Increase in cash and cash equivalents	18,590	57,169
Cash and cash equivalents at beginning of year	241,227	520,628
Cash and cash equivalents at end of period	$ 259,817	$ 577,797

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

The accompanying unaudited consolidated financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) for interim financial information. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation have been included and are of a normal and recurring nature. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2017.

2. Organization and Consolidation

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

The System is the leading provider of healthcare services in northeast Ohio. The System operates 14 hospitals with approximately 4,000 staffed beds. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by the Foundation. The System operates 21 outpatient family health centers, 10 ambulatory surgery centers, as well as numerous physician offices located throughout a seven-county area of northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada, and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, 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.

3. Business Combinations

Effective April 1, 2018, the Foundation though a subsidiary became the sole member of The Union Hospital Association (Union Hospital) through a non-cash business combination transaction. The business combination was recorded under the acquisition method of accounting. The System recorded the fair value of the assets acquired and the liabilities assumed as of April 1, 2018. The fair value of net assets of $65.4 million was recognized in the consolidated statement of operations and changes in net assets for the six months ended June 30, 2018 as a nonoperating member substitution contribution of $52.2 million, contributions of temporarily restricted net assets of $0.3 million and contributions of permanently restricted net assets of $12.9 million. There was no goodwill or identifiable intangible assets recorded as a result of the member substitution.

3. Business Combinations (continued)

The results of operations for Union Hospital are included in the consolidated statements of operations and changes in net assets beginning on April 1, 2018. For the three months ended June 30. 2018, Union Hospital had total unrestricted revenues of $30.7 million, operating loss of $3.4 million and a deficiency of revenues over expenses of $3.0 million. Union Hospital comprised approximately 0.7% of total consolidated operating revenues and 0.8% of total consolidated operating expenses in the first six months of 2018. The operations of Union Hospital did not have a material impact on temporarily and permanently restricted net assets.

Pro forma combined results of operations and changes in net assets of the System and Union Hospital for the six months ended June 30, 2018 and 2017, as though the business combination transactions had occurred on January 1, 2017, are not material and accordingly, are not provided.

4. 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, was effective for the System as of January 1, 2018.

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 is 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.

4. Accounting Policies (continued)

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.

5. 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.

6. Net Patient Service Revenue

Net patient service revenue is reported at the amount that reflects the consideration to which the System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors, and others and includes variable consideration for retroactive revenue adjustments due to settlement of reviews and audits. Generally, the System bills the patients and third-party payors several days after the services are performed or shortly after discharge. Revenue is recognized as performance obligations are satisfied.

6. Net Patient Service Revenue (continued)

Performance obligations are determined based on the nature of the services provided by the System. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges. The System believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services. The System measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. These services are considered to be a single performance obligation and have a duration of less than one year. Revenue for performance obligations satisfied at a point in time is recognized when services are provided and the System does not believe it is required to provide additional services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the System has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The System is utilizing the portfolio approach practical expedient in ASC 606 for contracts related to net patient service revenue. The System accounts for the contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio. As a result, the System has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract by contract basis.

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 and implicit price concessions as determined by the System. The System determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the System's policy, and implicit price concessions provided to uninsured patients. Implicit price concessions represent differences between amounts billed and the estimated consideration the System expects to receive from patients, which are determined based on historical collection experience, current market conditions and other factors. The System determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies, and historical experience.

6. Net Patient Service Revenue (continued)

Generally patients who are covered by third-party payors are responsible for patient responsibility balances, including deductibles and coinsurance, which vary in amount. The System estimates the transaction price for patients with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Adjustments arising from a change in the transaction price were not significant in the first six months of 2018 or 2017.

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.

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.

Settlements with third-party payors for retroactive adjustments due to reviews and audits are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care in the period the related services are provided. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the System's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known or as years are settled or are no longer subject to such reviews and audits. Adjustments arising from a change in the transaction price were not significant in the first six months of 2018 or 2017.

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.

6. Net Patient Service Revenue (continued)

Net patient service revenue by major payor source for the six months ended June 30, 2018 and 2017, are as follows (in thousands):

	2018		2017	
Medicare	**$ 1,433,471**	**37%**	$ 1,351,934	36%
Medicaid	**325,105**	**8**	304,702	8
Managed care and commercial	**2,124,088**	**55**	2,078,847	56
Self-pay	**14,316**	**–**	14,359	–
	$ 3,896,980	**100%**	$ 3,749,842	100%

As a result of certain changes required by ASU 2014-09, the majority of the System's provision for uncollectible accounts are recorded as a direct reduction to net patient service revenue instead of being presented as a separate line item on the consolidated statements of operations and changes in net assets. The adoption of ASU 2014-09 has no impact on the System's accounts receivable as it was historically recorded net of allowance for uncollectible accounts and contractual adjustments on the consolidated balance sheets. The impact of adopting ASU 2014-09 on the consolidated statements of operations and changes in net assets for the six months ended June 30, 2018 was as follows (in thousands):

	Six months ended June 30, 2018	
	As Reported	Prior to adopting ASU 2014-09
Net patient service revenue before provision for uncollectible accounts		$ 4,043,995
Provision for uncollectible accounts		(147,015)
Net patient service revenue	$ 3,896,980	$ 3,896,980

7. 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.

7. Fair Value Measurements (continued)

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.

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

7. Fair Value Measurements (continued)

The following tables present the financial instruments measured at fair value on a recurring basis as of June 30, 2018 and December 31, 2017, based on the valuation hierarchy (in thousands):

June 30, 2018	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 573,587	$ 10	$ –	$ 573,597
Fixed income securities:				
U.S. treasuries	1,190,015	–	–	1,190,015
U.S. government agencies	–	21,043	–	21,043
U.S. corporate	–	21,804	–	21,804
U.S. government agencies asset-backed securities	–	24,573	–	24,573
Corporate asset-backed securities	–	5,112	–	5,112
Foreign	–	7,696	–	7,696
Fixed income mutual funds	387,396	–	–	387,396
Common and preferred stocks:				
U.S.	499,716	–	–	499,716
Foreign	306,753	1,966	–	308,719
Equity mutual funds	103,967	–	–	103,967
Total cash and investments	3,061,434	82,204	–	3,143,638
Perpetual and charitable trusts	–	67,212	–	67,212
Total assets at fair value	$ 3,061,434	$ 149,416	$ –	$ 3,210,850
Liabilities				
Interest rate swaps	$ –	$ 96,906	$ –	$ 96,906
Total liabilities at fair value	$ –	$ 96,906	$ –	$ 96,906

7. Fair Value Measurements (continued)

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)

Financial instruments at June 30, 2018 and December 31, 2017 are reflected in the consolidated balance sheets as follows (in thousands):

	June 30 2018	December 31 2017
Cash, cash equivalents, and investments measured at fair value	**$ 3,143,638**	$ 3,427,464
Commingled funds measured at net asset value	**3,098,995**	2,948,317
Alternative investments accounted for under the equity method	**2,738,317**	2,481,560
Pending purchases of investments	**-**	215,000
Total cash, cash equivalents, and investments	**$ 8,980,950**	$ 9,072,341
Perpetual and charitable trusts measured at fair value	**$ 67,212**	$ 53,728
Interests in foundations	**26,861**	26,915
Trusts and interests in foundations	**$ 94,073**	$ 80,643

Interest rate swaps (Note 8) are reported in other noncurrent liabilities in the consolidated balance sheets.

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

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

The fair value of perpetual and charitable trusts in which the System receives periodic payments from the trust is determined based on the present value of expected cash flows to be received from the trust using discount rates ranging from 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 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. Derivative Instruments

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

The System's objective with respect to interest rate risk is to manage the risk of rising interest rates on the System's variable rate debt and certain variable rate operating lease payments. Consistent with its interest rate risk management objective, the System entered into various interest rate swap agreements with a total outstanding notional amount of $624.8 million and $615.0 million at June 30, 2018 and December 31, 2017, 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 gains (losses) in the consolidated statements of operations and changes in net assets.

8. Derivative Instruments (continued)

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

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at June 30 2018	Notional Amount at December 31 2017
Fixed	2021	3.21%	68% of LIBOR	**$ 30,145**	$ 31,725
Fixed	2024	3.42%	68% of LIBOR	**26,500**	27,200
Fixed	2027	3.56%	68% of LIBOR	**120,113**	124,303
Fixed	2028	5.12%	100% of LIBOR	**36,605**	37,730
Fixed	2028	3.51%	68% of LIBOR	**28,285**	29,125
Fixed	2030	5.07%	100% of LIBOR	**59,075**	59,075
Fixed	2030	5.06%	100% of LIBOR	**59,050**	59,050
Fixed	2031	3.04%	68% of LIBOR	**46,975**	49,850
Fixed	2032	4.32%	79% of LIBOR	**2,235**	2,279
Fixed	2032	4.33%	70% of LIBOR	**4,470**	4,557
Fixed	2032	3.78%	70% of LIBOR	**2,235**	2,279
Fixed	2036	4.90%	100% of LIBOR	**49,700**	49,700
Fixed	2036	4.90%	100% of LIBOR	**76,950**	76,950
Fixed	2037	4.62%	100% of SIFMA	**61,165**	61,165
Fixed	2039	4.62%	68% of LIBOR	**21,315**	-
				$ 624,818	$ 614,988

The System is exposed to fluctuations in various foreign currencies against its functional currency, the U.S. dollar (USD). The System used foreign currency derivatives including currency forward contracts and currency options to manage its exposure to fluctuations in the USD – British Pound (GBP) exchange rate. Currency forward contracts involve fixing the USD – GBP exchange rate for delivery of a specified amount of foreign currency on a specified date. The currency forward contracts are typically cash settled in USD for their fair value at or close to their settlement date. The System has also used currency option contracts to manage its foreign currency exchange risk. The foreign currency contracts were not designated as hedging instruments. At June 30, 2018 and December 31, 2017, the System has no outstanding foreign currency forward contracts.

8. Derivative Instruments (continued)

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

	Derivatives Liability			
	June 30, 2018		December 31, 2017	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 96,906**	Other noncurrent liabilities	$ 123,989

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

Derivatives not designated as hedging instruments	Location of Gain (Loss) Recognized	Quarter ended June 30		Six months ended June 30	
		2018	2017	2018	2017
Interest rate swap agreements	Derivative gains (losses)	**$ 5,691**	$ (7,815)	**$ 21,107**	$(6,600)
Foreign currency contracts	Derivative gains	**-**	1,576	**-**	2,417
		$ 5,691	$ (6,239)	**$ 21,107**	$(4,183)

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 June 30, 2018 and December 31, 2017, the System posted $49.1 million and $69.2 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.

9. 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 or Union Hospital. 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 covering System and Akron General employees. The System also assumed three additional defined contribution plans from the Union Hospital member substitution in April 2018. 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 or Union Hospital. 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 except those employed by Union Hospital. 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 components of net periodic benefit cost for defined benefit pension plans are as follows (in thousands):

	Quarter Ended June 30		Six Months Ended June 30	
	2018	**2017**	**2018**	**2017**
Amounts related to defined benefit pension plans:				
Service cost	$ (378)	$ 49	$ (757)	$ 98
Interest cost	16,178	17,836	32,356	35,672
Expected return on assets	(18,697)	(21,167)	(37,393)	(42,335)
Net amortization and deferral	(478)	(420)	(955)	(841)
Total defined benefit pension plans	(3,375)	(3,702)	(6,749)	(7,406)
Defined contribution plans	64,898	61,130	129,595	122,409
	$ 61,523	**$ 57,428**	**$ 122,846**	**$ 115,003**

9. Pensions and Other Postretirement Benefits (continued)

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

As June 30, 2018, the System has made contributions of $3.9 million to the defined benefit pension plans. The System expects to make additional contributions of $3.9 million to the defined benefit pension plans for the remainder of 2018.

10. Special Charges

The System incurred and recorded special charges of $1.8 million and $3.4 million in the first six months of 2018 and 2017, respectively, representing accelerated depreciation expense and other property, plant and equipment costs related to Lakewood Hospital Association (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 15 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 constructed an approximately 62,000-square-foot family health center that opened in July 2018 that is located adjacent to the site of the former hospital. LHA ceased inpatient operations at the hospital in February 2016, while the current emergency department and several outpatient services at the hospital continued until the opening of the new family health center and emergency department. The cessation of inpatient services at the hospital was not considered a discontinued operation since the System provides inpatient hospital services at the Foundation and its subsidiary hospitals in the Northeast Ohio area.

11. Subsequent Events

The System evaluated events and transactions occurring subsequent to June 30, 2018 through August 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, except that in August 2018 the System through a UK subsidiary entered into a private placement agreement to issue Guaranteed Senior Notes (2018 Sterling Notes) totaling £665 million. The subsidiary received £300 million in August 2018 and will receive additional proceeds on November 1, 2018 and August 1, 2019. The 2018 Sterling Notes are guaranteed by the Cleveland Clinic obligated group and another UK subsidiary, mature at various dates through 2068 and bear interest at an average fixed rate of 2.99%. The proceeds of the 2018 Sterling Notes have been or will be used to repay a $375.0 million term loan used to acquire a long-term leasehold interest in a building in London, England, and to partially fund the construction and conversion of the building into a healthcare facility.

Unaudited Consolidating Balance Sheets

($ in thousands)

	June 30, 2018				December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 76,442	$ 183,375	$ -	$ 259,817	$ 27,644	$ 213,583	$ -	$ 241,227
Patient receivables, net	985,975	152,477	(29,053)	1,109,399	904,105	142,450	(33,652)	1,012,903
Due from affiliates	14,609	30,434	(45,043)	-	55,942	50	(55,992)	-
Investments for current use	-	51,051	-	51,051	103,920	51,051	-	154,971
Other current assets	330,505	72,214	(2,940)	399,779	310,960	64,134	(368)	374,726
Total current assets	1,407,531	489,551	(77,036)	1,820,046	1,402,571	471,268	(90,012)	1,783,827
Investments:								
Long-term investments	7,294,642	480,119	-	7,774,761	7,289,000	440,697	-	7,729,697
Funds held by trustees	48,546	866	-	49,412	69,234	0	-	69,234
Assets held for self-insurance	-	112,996	-	112,996	-	159,802	-	159,802
Donor restricted assets	700,795	32,118	-	732,913	685,292	32,118	-	717,410
	8,043,983	626,099	-	8,670,082	8,043,526	632,617	-	8,676,143
Property, plant, and equipment, net	3,910,495	919,596	-	4,830,091	3,819,800	879,897	-	4,699,697
Other assets:								
Pledges receivable, net	155,295	599	-	155,894	150,690	329	-	151,019
Trusts and beneficial interests in foundations	72,433	21,640	-	94,073	71,866	8,777	-	80,643
Other noncurrent assets	576,836	65,158	(197,238)	444,756	566,548	60,388	(151,926)	475,010
	804,564	87,397	(197,238)	694,723	789,104	69,494	(151,926)	706,672
Total assets	$ 14,166,573	$ 2,122,643	$ (274,274)	$ 16,014,942	$ 14,055,001	$ 2,053,276	$ (241,938)	$ 15,866,339

	June 30, 2018				December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable	$ 382,890	$ 66,607	$ (190)	$ 449,307	$ 432,859	$ 71,024	$ (192)	$ 503,691
Compensation and amounts withheld from payroll	355,301	38,279	-	393,580	311,159	34,287	-	345,446
Short-term borrowings	-	-	-	-	0	0	-	-
Current portion of long-term debt	80,000	380,175	(72)	460,103	77,208	380,677	(72)	457,813
Variable rate debt classified as current	438,940	58,880	-	497,820	514,396	58,874	-	573,270
Due to affiliates	26	14,609	(14,635)	-	50	55,942	(55,992)	-
Other current liabilities	363,393	113,283	(31,677)	444,999	358,475	116,352	(36,165)	438,662
Total current liabilities	1,620,550	671,833	(46,574)	2,245,809	1,694,147	717,156	(92,421)	2,318,882
Long-term debt:								
Hospital revenue bonds	2,871,934	-	-	2,871,934	2,861,438	0	-	2,861,438
Notes payable and capital leases	151,595	215,411	(192,694)	174,312	110,675	171,562	(147,397)	134,840
	3,023,529	215,411	(192,694)	3,046,246	2,972,113	171,562	(147,397)	2,996,278
Other liabilities:								
Professional and general insurance liability reserves	57,006	83,766	-	140,772	55,875	91,452	-	147,327
Accrued retirement benefits	446,184	37,965	-	484,149	453,710	39,123	-	492,833
Other noncurrent liabilities	501,129	73,407	(32,886)	541,650	526,814	40,752	-	567,566
	1,004,319	195,138	(32,886)	1,166,571	1,036,399	171,327	-	1,207,726
Total liabilities	5,648,398	1,082,382	(272,154)	6,458,626	5,702,659	1,060,045	(239,818)	6,522,886
Net assets:								
Unrestricted	7,540,606	984,765	(2,120)	8,523,251	7,397,798	950,971	(2,120)	8,346,649
Temporarily restricted	653,130	24,105	-	677,235	638,208	23,981	-	662,189
Permanently restricted	324,439	31,391	-	355,830	316,336	18,279	-	334,615
Total net assets	8,518,175	1,040,261	(2,120)	9,556,316	8,352,342	993,231	(2,120)	9,343,453
Total liabilities and net assets	$ 14,166,573	$ 2,122,643	$ (274,274)	$ 16,014,942	$ 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 Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended June 30, 2018				Three Months Ended June 30, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue before provision for uncollectible accounts					$ 1,794,338	$ 233,509	$ (64,573)	$ 1,963,274
Provision for uncollectible accounts					(66,273)	(16,442)	-	(82,715)
Net patient service revenue	$ 1,813,932	$ 243,312	$ (70,038)	$ 1,987,206	1,728,065	217,067	(64,573)	1,880,559
Other	181,284	77,834	(38,082)	221,036	239,971	81,144	(37,217)	283,898
Total unrestricted revenues	1,995,216	321,146	(108,120)	2,208,242	1,968,036	298,211	(101,790)	2,164,457
Expenses								
Salaries, wages, and benefits	1,132,695	173,685	(80,885)	1,225,495	1,082,810	147,662	(72,168)	1,158,304
Supplies	184,286	29,794	(238)	213,842	172,635	27,116	(327)	199,424
Pharmaceuticals	251,899	20,445	-	272,344	215,480	18,931	-	234,411
Purchased services and other fees	124,601	22,998	(5,106)	142,493	110,948	29,880	(7,255)	133,573
Administrative services	40,356	21,015	(5,319)	56,052	38,401	15,162	(4,820)	48,743
Facilities	71,105	19,072	(854)	89,323	64,405	15,837	(1,055)	79,187
Insurance	19,834	18,306	(15,693)	22,447	17,733	19,107	(16,165)	20,675
	1,824,776	305,315	(108,095)	2,021,996	1,702,412	273,695	(101,790)	1,874,317
Operating income before interest, depreciation, and amortization expenses	170,440	15,831	(25)	186,246	265,624	24,516	-	290,140
Interest	29,937	4,552	-	34,489	32,893	2,818	-	35,711
Depreciation and amortization	109,114	16,613	(25)	125,702	107,107	15,438	-	122,545
Operating income (loss) before special charges	31,389	(5,334)	-	26,055	125,624	6,260	-	131,884
Special charges	-	954	-	954	-	1,426	-	1,426
Operating income (loss)	31,389	(6,288)	-	25,101	125,624	4,834	-	130,458
Nonoperating gains and losses								
Investment return	(363)	(468)	-	(831)	160,402	13,051	-	173,453
Derivative gains (losses)	5,986	(295)	-	5,691	(5,642)	(597)	-	(6,239)
Other, net	1,597	49,153	-	50,750	2,626	2,981	-	5,607
Net nonoperating gains and losses	7,220	48,390	-	55,610	157,386	15,435	-	172,821
Excess of revenues over expenses	38,609	42,102	-	80,711	283,010	20,269	-	303,279

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)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at April 1, 2017	$ 7,450,031	$ 924,694	$ (3,448)	$ 8,371,277
Excess of revenues over expenses	283,010	20,269	-	303,279
Donated capital, excluding assets released from restrictions for capital purposes	-	-	-	-
Restricted gifts and bequests	21,586	(2)	-	21,584
Restricted net investment income	9,396	799	-	10,195
Net assets released from restrictions used for operations included in other unrestricted revenues	(8,122)	(645)	-	(8,767)
Contributions (to) from affiliates	(22,759)	22,759	-	-
Retirement benefits adjustment	(659)	-	-	(659)
Change in restricted net assets related to interests in foundations	3,162	-	-	3,162
Change in restricted net assets related to value of perpetual trusts	354	145	-	499
Foreign currency translation	(42)	12,922	-	12,880
Net change in unrealized gains on nontrading investments	403	-	-	403
Other	2	199	-	201
Increase in total net assets	286,331	56,446	-	342,777
Total net assets at June 30, 2017	$ 7,736,362	$ 981,140	$ (3,448)	$ 8,714,054
Total net assets at April 1, 2018	$ 8,469,788	$ 1,007,169	$ (2,120)	$ 9,474,837
Excess of revenues over expenses	38,609	42,102	-	80,711
Donated capital, excluding assets released from restrictions for capital purposes	460	-	-	460
Restricted gifts and bequests	20,125	1,088	-	21,213
Restricted net investment income	(221)	222	-	1
Net assets released from restrictions used for operations included in other unrestricted revenues	(9,078)	(863)	-	(9,941)
Transfers (to) from affiliates	(233)	233	-	-
Member substitution	-	13,180	-	13,180
Retirement benefits adjustment	(659)	(58)	-	(717)
Change in restricted net assets related to interests in foundations	(54)	-	-	(54)
Change in restricted net assets related to value of perpetual trusts	200	68	-	268
Foreign currency translation	-	(22,846)	-	(22,846)
Other	(762)	(34)	-	(796)
Increase in total net assets	48,387	33,092	-	81,479
Total net assets at June 30, 2018	$ 8,518,175	$ 1,040,261	$ (2,120)	$ 9,556,316

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

	Six Months Ended June 30, 2018				Six Months Ended June 30, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue before for uncollectible accounts					$ 3,582,068	$ 461,539	$ (121,954)	$ 3,921,653
Provision for uncollectible accounts					(140,840)	(30,971)	-	(171,811)
Net patient service revenue	$ 3,577,625	$ 457,322	$ (137,967)	$ 3,896,980	3,441,228	430,568	(121,954)	3,749,842
Other	365,562	143,252	(75,101)	433,713	412,370	151,996	(80,848)	483,518
Total unrestricted revenues	3,943,187	600,574	(213,068)	4,330,693	3,853,598	582,564	(202,802)	4,233,360
Expenses								
Salaries, wages, and benefits	2,245,196	322,558	(159,039)	2,408,715	2,165,181	289,379	(139,019)	2,315,541
Supplies	366,159	51,282	(400)	417,041	342,455	51,056	(462)	393,049
Pharmaceuticals	485,929	40,640	-	526,569	419,590	38,486	-	458,076
Purchased services and other fees	234,076	46,669	(9,992)	270,753	213,510	65,296	(19,107)	259,699
Administrative services	70,113	36,508	(10,592)	96,029	72,247	30,545	(9,998)	92,794
Facilities	139,478	36,684	(1,609)	174,553	131,687	32,762	(1,885)	162,564
Insurance	37,115	36,592	(31,386)	42,321	35,081	38,074	(32,331)	40,824
	3,578,066	570,933	(213,018)	3,935,981	3,379,751	545,598	(202,802)	3,722,547
Operating income before interest, depreciation, and amortization expenses	365,121	29,641	(50)	394,712	473,847	36,966	-	510,813
Interest	59,308	8,182	-	67,490	66,528	5,356	-	71,884
Depreciation and amortization	220,373	32,434	(50)	252,757	214,589	29,785	-	244,374
Operating income (loss) before special charges	85,440	(10,975)	-	74,465	192,730	1,825	-	194,555
Special charges	-	1,788	-	1,788	-	3,384	-	3,384
Operating income (loss)	85,440	(12,763)	-	72,677	192,730	(1,559)	-	191,171
Nonoperating gains and losses								
Investment return	33,836	2,437	-	36,273	384,608	31,527	-	416,135
Derivative gains (losses)	21,926	(819)	-	21,107	(2,963)	(1,220)	-	(4,183)
Other, net	3,191	53,935	-	57,126	5,201	3,518	-	8,719
Net nonoperating gains and losses	58,953	55,553	-	114,506	386,846	33,825	-	420,671
Excess of revenues over expenses	144,393	42,790	-	187,183	579,576	32,266	-	611,842

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)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2017	$ 7,143,389	$ 885,858	$ (3,448)	$ 8,025,799
Excess of revenues over expenses	579,576	32,266	-	611,842
Restricted gifts and bequests	48,387	800	-	49,187
Restricted net investment income	22,828	1,769	-	24,597
Net assets released from restrictions used for operations included in other unrestricted revenues	(15,335)	(1,326)	-	(16,661)
Contributions (to) from affiliates	(44,581)	44,581	-	-
Retirement benefits adjustment	(1,317)	-	-	(1,317)
Change in restricted net assets related to interest in foundations	3,162	-	-	3,162
Change in restricted net assets related to value of perpetual trusts	765	279	-	1,044
Foreign currency translation	(63)	16,616	-	16,553
Net change in unrealized losses on nontrading investments	(430)	-	-	(430)
Other	(19)	297	-	278
Increase in total net assets	592,973	95,282	-	688,255
Total net assets at June 30, 2017	$ 7,736,362	$ 981,140	$ (3,448)	$ 8,714,054
Total net assets at January 1, 2018	$ 8,352,342	$ 993,231	$ (2,120)	$ 9,343,453
Excess of revenues over expenses	144,393	42,790	-	187,183
Donated capital, excluding assets released from restrictions for capital purposes	460	-	-	460
Restricted gifts and bequests	45,274	1,148	-	46,422
Restricted net investment income	(486)	687	-	201
Net assets released from restrictions used for operations included in other unrestricted revenues	(21,802)	(1,590)	-	(23,392)
Transfers (to) from affiliates	(556)	556	-	-
Member substitution	-	13,180	-	13,180
Retirement benefits adjustment	(1,317)	(115)	-	(1,432)
Change in restricted net assets related to interests in foundations	(54)	-	-	(54)
Change in restricted net assets related to value of perpetual trusts	683	215	-	898
Foreign currency translation	-	(9,846)	-	(9,846)
Other	(762)	5	-	(757)
Increase in total net assets	165,833	47,030	-	212,863
Total net assets at June 30, 2018	$ 8,518,175	$ 1,040,261	$ (2,120)	$ 9,556,316

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)

	Six Months Ended June 30, 2018				Six Months Ended June 30, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Operating activities and net nonoperating gains and losses								
Increase in total net assets	$ 165,833	$ 47,030	$ -	$ 212,863	$ 592,973	$ 95,282	$ -	$ 688,255
Adjustments to reconcile increase in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:								
Retirement benefits adjustment	1,317	115	-	1,432	1,317	-	-	1,317
Net realized and unrealized (gains) losses on investments	(11,438)	158	-	(11,280)	(383,854)	(32,257)	-	(416,111)
Depreciation and amortization	220,373	34,029	(50)	254,352	214,589	31,574	-	246,163
Provision for uncollectible accounts	-	-	-	-	140,840	30,971	-	171,811
Foreign currency translation gain	-	9,846	-	9,846	63	(16,616)	-	(16,553)
Donated capital	(460)	-	-	(460)	-	-	-	-
Restricted gifts, bequests, investment income, and other	(45,417)	(2,050)	-	(47,467)	(75,142)	(2,848)	-	(77,990)
Transfers to (from) affiliates	556	(556)	-	-	44,581	(44,581)	-	-
Accreted interest and amortization of bond premiums	(3,061)	6	-	(3,055)	(739)	6	-	(733)
Net gain in value of derivatives	(27,083)	(2,575)	-	(29,658)	(12,773)	-	-	(12,773)
Member substitution	-	(65,442)	-	(65,442)	-	-	-	-
Changes in operating assets and liabilities:								
Patient receivables	(81,870)	10,880	(4,599)	(75,589)	(92,636)	(51,417)	7,833	(136,220)
Other current assets	22,912	(34,354)	(8,377)	(19,819)	(11,359)	(34,633)	30,196	(15,796)
Other noncurrent assets	(10,653)	(1,133)	45,362	33,576	45,694	7,796	(7,487)	46,003
Accounts payable and other current liabilities	11,604	(53,535)	45,847	3,916	(36,584)	(10,205)	(4,299)	(51,088)
Other liabilities	(6,314)	23,459	(32,886)	(15,741)	(6,967)	35,748	(33,730)	(4,949)
Net cash provided by (used in) operating activities and net nonoperating gains and losses	236,299	(34,122)	45,297	247,474	420,003	8,820	(7,487)	421,336
Financing activities								
Proceeds from long-term borrowings	45,000	45,297	(45,297)	45,000	-	13	(13)	-
Principal payments on long-term debt	(70,349)	(47,024)	-	(117,373)	(76,557)	(2,049)	7,500	(71,106)
Change in pledges receivable, trusts and interests in foundations	(6,296)	(237)	-	(6,533)	(9,584)	(113)	-	(9,697)
Restricted gifts, bequests, investment income, and other	45,417	2,050	-	47,467	75,142	2,848	-	77,990
Net cash provided by (used in) financing activities	13,772	86	(45,297)	(31,439)	(10,999)	699	7,487	(2,813)
Investing activities								
Expenditures for property and equipment	(315,618)	(41,013)	-	(356,631)	(239,002)	(24,828)	-	(263,830)
Member substitution cash contribution	-	1,515	-	1,515	-	-	-	-
Net change in cash equivalents reported in long-term investments	214,384	38,134	-	252,518	(173,547)	9,748	-	(163,799)
Purchases of investments	(1,156,881)	(99,111)	-	(1,255,992)	(1,136,138)	(97,373)	-	(1,233,511)
Sales of investments	1,057,398	105,881	-	1,163,279	1,214,609	84,323	-	1,298,932
Transfers (to) from affiliates	(556)	556	-	-	(44,581)	44,581	-	-
Net cash (used in) provided by investing activities	(201,273)	5,962	-	(195,311)	(378,659)	16,451	-	(362,208)
Effect of exchange rate changes on cash	-	(2,134)		(2,134)	(63)	917		854
Increase (decrease) in cash and cash equivalents	48,798	(30,208)	-	18,590	30,282	26,887	-	57,169
Cash and cash equivalents at beginning of year	27,644	213,583	-	241,227	303,102	217,526	-	520,628
Cash and cash equivalents at end of period	$ 76,442	$ 183,375	$ -	$ 259,817	$ 333,384	$ 244,413	$ -	$ 577,797

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.

Utilization

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

	Year Ended December 31			YTD June 30	
	2015[2]	2016	2017	2017	2018[3]
Total Staffed Beds[1]	4,034	3,931	3,847	3,914	4,046
Percent Occupancy[1]	67.9%	69.3%	70.7%	71.2%	70.8%
Inpatient Admissions[1]					
Acute	146,990	162,930	169,238	85,644	84,784
Post-acute	11,779	12,424	11,710	5,998	5,449
Total	158,769	175,354	180,948	91,642	90,233
Patient Days[1]					
Acute	782,316	846,170	877,891	443,505	446,823
Post-acute	98,268	103,979	93,961	49,469	39,667
Total	880,584	950,149	971,852	492,974	486,490
Average Length of Stay					
Acute	5.30	5.20	5.16	5.15	5.28
Post-acute	8.30	8.39	8.04	8.30	7.41
Surgical Facility Cases					
Inpatient	56,311	59,802	61,529	31,602	31,087
Outpatient	137,139	147,855	145,825	77,008	75,991
Total	193,450	207,657	207,354	108,610	107,078
Emergency Room Visits	542,768	652,073	644,575	323,531	330,443
Outpatient Observations	49,237	58,384	59,894	30,609	30,486
Outpatient Evaluation and Management Visits	3,742,901	4,235,729	4,403,635	2,245,241	2,271,717
Acute Medicare Case Mix Index - Health System	1.91	1.93	1.91	1.90	1.95
Acute Medicare Case Mix Index - Cleveland Clinic	2.47	2.53	2.59	2.58	2.69
Total Acute Patient Case Mix Index - Health System	1.81	1.84	1.85	1.84	1.90
Total Acute Patient Case Mix Index - Cleveland Clinic	2.36	2.45	2.52	2.49	2.62

(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.
(3) Includes Union Hospital statistics beginning April 1, 2018, which is the date the Clinic became the sole member of The Union Hospital Association.

Utilization (continued)

The following table provides selected utilization statistics for the Obligated Group:

	Year Ended December 31			YTD June 30	
	2015	2016	2017	2017	2018
Total Staffed Beds[(1)]	3,352	3,412	3,352	3,382	3,412
Percent Occupancy[(1)]	69.6%	69.6%	70.8%	71.8%	72.1%
Inpatient Admissions[(1)]					
Acute	138,287	139,300	145,479	73,642	72,363
Post-acute	9,740	9,471	8,980	4,941	4,376
Total	148,027	148,771	154,459	78,583	76,739
Patient Days[(1)]					
Acute	747,231	744,296	767,003	386,440	389,947
Post-acute	73,473	76,113	70,567	41,668	31,851
Total	820,704	820,409	837,570	428,108	421,798
Surgical Facility Cases					
Inpatient	53,839	54,072	56,030	28,294	27,945
Outpatient	132,800	135,918	133,893	68,586	67,242
Total	186,639	189,990	189,923	96,880	95,187
Emergency Room Visits	493,930	535,478	530,316	267,138	264,379
Outpatient Observations	45,687	50,671	52,506	26,819	26,124
Outpatient Evaluation and Management Visits	3,742,901	4,232,729	4,399,738	2,243,224	2,269,772
Acute Medicare Case Mix Index	1.86	1.91	1.90	1.89	1.94
Total Acute Patient Case Mix Index	1.76	1.83	1.84	1.83	1.89

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

Payor Mix

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

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD June 30	
	2015[1]	2016	2017	2017	2018[2]
Payor					
Managed Care and Commercial	42%	39%	38%	39%	37%
Medicare	43%	44%	46%	45%	47%
Medicaid	12%	14%	14%	14%	14%
Self-Pay & Other	3%	3%	2%	2%	2%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD June 30	
	2015	2016	2017	2017	2018
Payor					
Managed Care and Commercial	42%	40%	39%	39%	38%
Medicare	43%	44%	46%	46%	47%
Medicaid	12%	13%	13%	13%	13%
Self-Pay & Other	3%	3%	2%	2%	2%
Total	100%	100%	100%	100%	100%

(1) Includes Akron General payor mix for November and December 2015. The Clinic became the sole member of Akron General on November 1, 2015.
(2) Includes Union Hospital statistics beginning April 1, 2018, which is the date the Clinic became the sole member of The Union Hospital Association.

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.

Research Support

($ in thousands)

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

	Year Ended December 31			YTD June 30	
	2015	**2016**	**2017**	**2017**	**2018**
External Grants Earned					
Federal Sources	$103,022	$108,253	$114,942	$58,517	$58,796
Non-Federal Sources	81,796	87,883	92,564	47,366	51,163
Total	184,818	196,136	207,506	105,883	109,959
Internal Support	63,240	59,326	59,873	27,028	29,970
Total Sources of Support	$248,058	$255,462	$267,379	$132,911	$139,929

Key Ratios

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

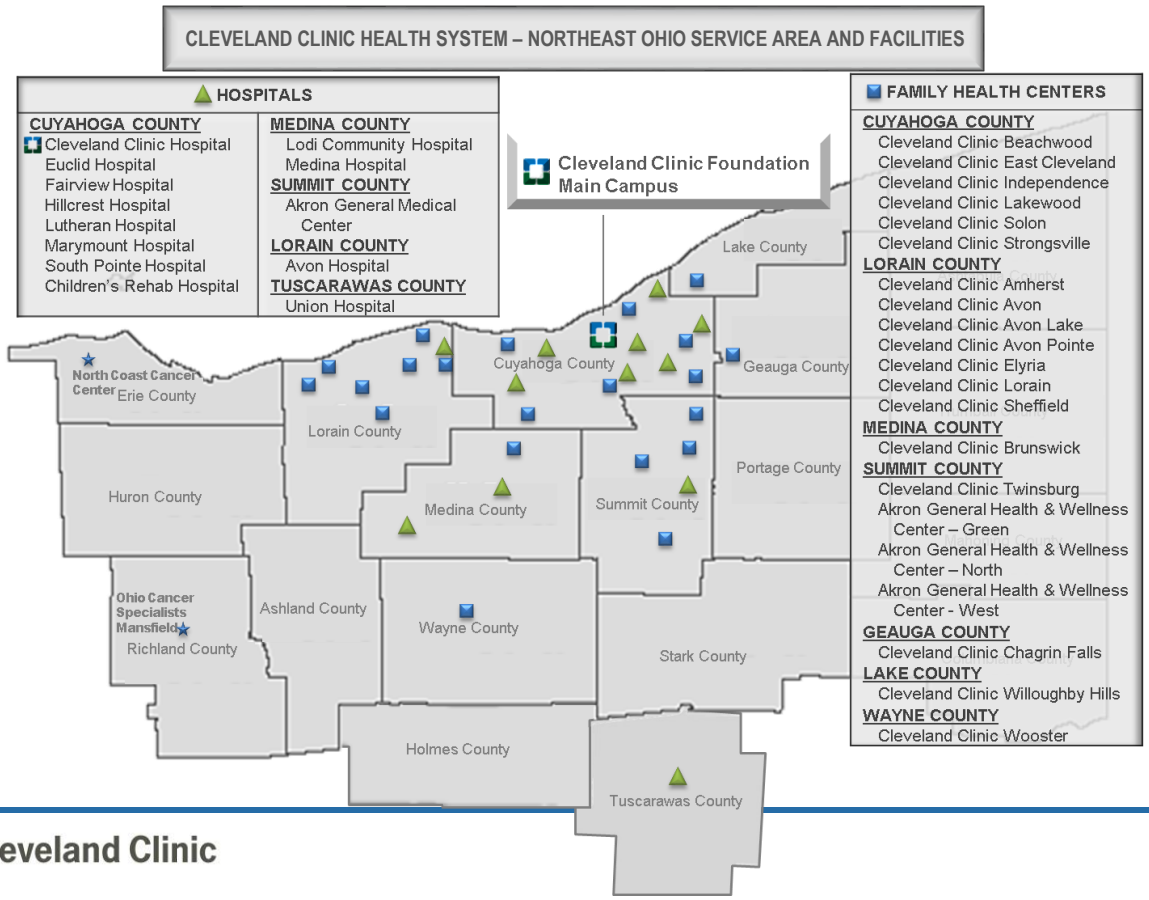
	Year Ended December 31			YTD June 30	
	2015	2016	2017	2017	2018
Liquidity ratios					
Days of cash on hand	347	349	383	368	371
Days of revenue in accounts receivable	47	51	49	50	51
Coverage ratios					
Cash to debt (%)	168.9	172.7	197.9	188.5	200.7
Maximum annual debt service coverage (x)	5.7	3.8	5.3	5.0	5.0
Interest expense coverage (x)	10.1	7.5	9.1	9.3	9.1
Debt to cash flow (x)	3.4	4.6	3.5	3.4	3.6
Leverage ratio					
Debt to capitalization (%)	36.5	36.4	32.5	33.9	32.0
Profitability ratios					
Operating margin (%)	6.7	3.0	3.9	4.5	1.7
Operating cash flow margin (%)	14.7	11.0	11.5	12.1	9.1
Excess margin (%)	8.5	6.2	12.5	13.1	4.2
Return on assets (%)	4.5	3.6	7.3	8.2	2.3

NOTE:
Coverage and liquidity ratios are calculated using a 12-month rolling income statement.

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 14 hospitals with approximately 4,000 staffed beds and is the leading provider of healthcare services in northeast Ohio. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates 21 outpatient family health centers 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.

Effective April 1, 2018, the Clinic through a subsidiary became the sole member of The Union Hospital Association (Union Hospital) through a non-cash business combination transaction. Union Hospital operates a hospital and several off-campus satellite services in Tuscarawas County and surrounding counties in Eastern Ohio. For a description of Union Hospital, refer to "UNION HOSPITAL."



The following table sets forth the hospitals operated by the obligated issuers and their affiliates, together with each hospital's staffed bed count as of June 30, 2018:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,302
Avon Hospital	126
Euclid Hospital	165
Fairview Hospital	460
Hillcrest Hospital	440
Lutheran Hospital	194
Marymount Hospital	277
Medina Hospital	121
South Pointe Hospital	172
Weston Hospital	155
	3,412
NON-OBLIGATED	
Akron General Medical Center	450
Union Hospital	139
Children's Rehab Hospital	25
Lodi Hospital	20
	634
HEALTH SYSTEM	4,046

AWARDS & RECOGNITION

The Clinic was ranked as the second best hospital in the United States by *U.S. News and World Report* in its 2018-2019 edition of "America's Best Hospitals." For the past 20 years, the Clinic has been 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-four consecutive years. The Clinic has additionally received the honor of being recognized with the best urology program in the United States for the second straight year. The Clinic was nationally ranked in fourteen specialties, including twelve in the top five nationwide, and is one of just twenty hospitals to earn a place on the *U.S. News'* 2018-2019 Honor Roll. The following table summarizes the Clinic's national rankings by medical specialty:

2018-19 U.S. NEWS & WORLD REPORT RANKINGS

BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2018-19

In the "HONOR ROLL"

Cleveland Clinic	2nd

Ranked No. 1

Cardiology & Heart Surgery	1st
Urology	1st

In America's Top 5

Gastroenterology & GI Surgery	2nd
Nephrology	2nd
Rheumatology	2nd
Orthopedics	3rd
Pulmonology	3rd
Diabetes & Endocrinology	4th
Neurology & Neurosurgery	4th
Cancer	5th
Geriatrics	5th
Gynecology	5th

In America's Top 20

Ophthalmology	9th
Ear, Nose & Throat	11th

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 ten out of ten medical specialties ranked by *U.S. News and World Report* in its 20188-2019 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 three of the System's regional hospitals in the top hospitals in the Cleveland metropolitan area and Ohio: Fairview Hospital ranked third in Cleveland and fifth in Ohio; Hillcrest Hospital ranked fourth in Cleveland and sixth in Ohio; and South Pointe Hospital ranked fifth in Cleveland and thirteenth in Ohio. Akron General Medical Center, located in Summit County, was ranked eleventh in the State of Ohio. Weston Hospital was ranked first in the Miami-Fort Lauderdale metro area and fourth 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.

Akron General Medical Center achieved its second 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.

Akron General is the System's fifth hospital to receive Magnet designation. The Clinic received its first designation in 2003, Fairview Hospital was designated in 2009, Hillcrest was designated in 2014, and South Pointe was designated in 2017. Akron General first designation of Magnet status was received in 2013.

In January 2018, three of the System's Heart and Vascular Institute units received the Beacon Award for Excellence at the gold level. The Beacon award was created by the American Association of Critical Care Nurses to recognize hospital units for demonstrating exceptional care through improved outcomes, greater overall satisfaction and a positive and supportive work environment. Units are recognized at the gold, silver or bronze level, and the designation continues for three years. The Orthopedic Nursing Unit at Euclid Hospital was also honored in 2018 at the silver level. Other Cleveland Clinic units that have received the Beacon award are the main campus Heart Failure Intensive Care Unit and Coronary Intensive Care Unit, both at the gold level in 2015, and the Hillcrest Hospital Coronary Care Unit at the silver level in 2016.

In August 2018, the Parkinson's Foundation named the Clinic a Center of Excellence, a designation that recognizes hospitals and academic medical centers that provide the latest medications, therapies and innovations in Parkinson's disease. Organizations are required to meet various clinical, research, professional education and patient care criteria to be considered for the Center of Excellence designation. The Clinic is one of 45 medical centers in the world and 31 in the U.S. that received the Center of Excellence designation from the Parkinson's Foundation.

The Clinic was recognized among twenty Cleveland area employers at the 2018 Smart Culture Conference by *Smart Business* magazine for the second consecutive year. Honorees were noted for having workplace cultures that bolster productivity, enhance job satisfaction and provide a competitive advantage in the marketplace.

The System was recognized by *The Plain Dealer* newspaper as one of Northeast Ohio's 150 top workplaces for 2018, ranking seventeenth 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 sixth time on this list.

The Clinic's CEO and President, Tomislav Mihaljevic, M.D., was named the sixteenth most influential physician executive in the nation by *Modern Healthcare* in its 2018 list of the fifty most influential physician executives and leaders. The list honors physicians working in the healthcare industry who are recognized by their peers and an expert panel as being influential in terms of demonstrated leadership and impact. Dr. Mihaljevic was recognized for his focus on new initiatives that the organization will pursue in 2018, including improvements in patient safety, caregiver experience and operational efficiency.

FINANCING DEVELOPMENTS

In August 2018 the System through a UK subsidiary entered into a private placement agreement to issue Guaranteed Senior Notes (2018 Sterling Notes) totaling £665 million. The subsidiary received £300 million in August 2018 and will receive additional proceeds on November 1, 2018 and August 1, 2019. The 2018 Sterling Notes are guaranteed by the Cleveland Clinic obligated group and another UK subsidiary, mature at various dates through 2068 and bear interest at an average fixed rate of 2.99%. The proceeds of the 2018 Sterling Notes have been or will be used to repay a $375.0 million term loan used to acquire a long-term leasehold interest in a building in London, England, and to partially fund the construction and conversion of the building into a healthcare facility. The 2018 Sterling Notes were assigned a rating of AA by Standard & Poor's (S&P).

At the time the 2018 Sterling Notes were rated, S&P affirmed its AA rating on the System's obligated group outstanding debt and maintained its stable outlook. S&P cited various reasons to support the rating, including a unique and very strong enterprise profile, continued widespread brand recognition of tertiary and quaternary services and a stable leadership team that has executed on its strategy and vision. S&P noted the System's robust research program, increasing emphasis on teaching, and strategic focus on growth domestically and internationally. 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 July 2018 Moody's Investor Services (Moody's) affirmed its 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 local market position, high degree of integration and centralization, strong liquidity with sustained good operating 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, execution risks of multiple strategies that require elevated capital spending and constrained revenue in the local market due to competition and weak demographic trends.

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 28 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 73 active Trustees and 14 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:

- Audit Committee
- Board Policy Committee
- Compensation Committee
- Conflict of Interest and Managing Innovations Committee
- Finance Committee
- Governance Committee
- Government and Community Relations Committee
- Investment Committee
- Medical Staff Appointment Committee
- Philanthropy Committee
- Quality, Safety and Patient Experience Committee
- Research and Education Committee

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. Each regional hospital has a president, and all hospital presidents report to the President of Regional Hospitals and Family Health Centers.

Lerner Research Institute
Cleveland, Ohio

APPOINTMENTS

Tomislav "Tom" Mihaljevic, MD was appointed Chief Executive Officer (CEO) and President of the Cleveland Clinic effective January 1, 2018. Dr. Mihaljevic replaced Toby Cosgrove, MD, who transitioned out of the CEO role in 2017 and now serves in an advisory role. 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 was appointed Chief Executive Officer of Cleveland Clinic London in 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 Chief Executive Officer of Cleveland Clinic Abu Dhabi in January 2018 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 was appointed Chief of Staff in 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 was appointed to the new role of President – Cleveland Clinic Main Campus in 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 President of the Regional Hospitals and Family Health Centers, succeeding J. Stephen Jones, MD.

James Young, MD was appointed Chief Academic Officer in March 2018 to 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.

Adam Myers, MD, FACHE was appointed Chief of Population Health and Director of Cleveland Clinic Community Care in June 2018. Cleveland Clinic Community Care was launched in 2017 to manage populations of patients rather than just addressing individual patients' needs on a visit-by-visit basis with a goal of reducing the cost of healthcare while improving quality initiatives and metrics. Dr. Myers most recently served as Senior Vice President, Chief Medical Officer and Operations Officer of Texas Health Physicians Group/Enterprise and Chair of the Clinical Integration team at Southwestern Health Resources.

Josette M. Beran was appointed Chief Strategy Officer in August 2018. Ms. Beran has served in various leadership roles during her 17-year career at the Clinic, including Executive Administrative Officer at Cleveland Clinic Abu Dhabi from 2011-2014 and Executive Director and Interim Chief Strategy Officer in the Clinic's Strategy Office since 2014. During her roles in the Strategy Office, Ms. Beran led the integration of Akron General and Union Hospital into the System and the development of potential acquisition opportunities in Florida.

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 July 2018, Akron General Medical Center completed and opened a $49 million emergency department. The two-story, 73,000 square foot emergency department triples the size of the former emergency department space. The first floor houses the emergency department, and the second floor contains administrative offices and a clinical decision unit for patients that need short-term observation care. The facility is a Level 1 trauma center and has a total of 60 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 second floor houses a clinical decision unit that has capacity for up to 18 short-term observation patient beds and the rooftop has a helipad.

In July 2018, the Clinic completed and opened a new 64,700 square foot, three story family health center in Lakewood, Ohio on a site adjacent to the former Lakewood Hospital. The $34 million facility has an emergency department located on the first floor with 16 treatment rooms. On the second and third floors, the facility has 60 exam rooms. There is also lab and imaging services to support operations at the facility.

In July 2018, Cleveland Clinic Florida completed construction on a new $32 million 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 accommodates approximately forty exam rooms, four operating rooms with shell space for two additional operating rooms in the future, two endoscopy rooms and imaging services. The project was completed through a joint venture with a local Florida developer. A construction loan was obtained by the joint venture for the majority of the construction costs with a guarantee provided by affiliates of the Florida developer. Cleveland Clinic Florida is leasing the building from the joint venture on a triple net basis for an initial term of 15 years and will provide the clinical operations in the facility.

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

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, Akron General Medical Center and Lodi Hospital implemented EAPM in the third quarter of 2017, and Fairview and Lutheran Hospitals implemented EAPM in the second quarter of 2018. Implementation for other System hospitals is planned in phases throughout the remainder of 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 fourth 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 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 October 2018.

Cleveland Clinic London Hospital – In 2015, the Clinic acquired a long-term leasehold interest in a six-story 198,000 square foot building in London, England. In January 2017, regulatory approvals were received to convert the building from office space into an approximately 200-bed hospital with eight operating theatres. Construction on the London Hospital is expected to be completed in 2020 and open for patients in early 2021. The System through a UK subsidiary entered into a private placement agreement in August 2018 to repay a term loan that was used to finance the acquisition costs and to fund a portion of the construction and conversion costs of the facility. For a description of the London hospital financing, refer to "FINANCING DEVELOPMENTS."

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 June 30, 2018, the Clinic has received pledges, cash and other assets of approximately $1.4 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, renovation of vacated space, new facilities in Florida and other building projects at its Northeast Ohio 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 AND VENTURES

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 84 companies, transacted more than 554 technology licenses, filed over 4,000 patent applications with over 1,450 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.

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. The first cohort of companies completed the three-month Plug & Play Cleveland program in June 2018. The accelerator connects 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 2018 Medical Innovation Summit will be held in October 2018 in downtown Cleveland. The 2017 Summit and its affiliated events hosted 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 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.

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.

In July 2018, the Clinic and CWRU unveiled plans to work together to advance research and education in biomedical engineering. The goal is to create a portfolio of laboratory breakthroughs that improve treatments for patients and to establish a framework for creating more joint efforts between the organizations with increased opportunities for trainees to study with scientists, physicians and engineers. The current alliance includes more than 50 researchers with primary appointments in biomedical engineering and another 80 CWRU researchers appointed in such disciplines as cardiology, ophthalmology, orthopedics and precision medicine.

JOINT VENTURES

Under a joint venture agreement with Select Medical, one of the nation's largest providers of post-acute care services, 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. 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. The Clinic is a minority member in the joint venture.

The Clinic and Select Medical entered into a joint venture agreement in July 2016 to operate four existing long-term acute care (LTAC) facilities in northeast Ohio with a total of 230 beds. The joint venture expands the Clinic's relationship with Select Medical and combines the experience of both organizations in the treatment of LTAC patients.

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 healthcare 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 transitioned 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 System's physicians, specialties and facilities, as well as independent physicians who are part of the Cleveland Clinic Quality Alliance.

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 15 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 constructed an approximately 62,000-square-foot family health center that opened in July 2018 that is located adjacent to the site of the former hospital. LHA ceased inpatient operations at the hospital in

February 2016, while the current emergency department and several outpatient services at the hospital continued 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 were 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 trial court dismissed the case on July 10, 2017, but the Plaintiffs appealed the dismissal. On May 10, 2018, the Court of Appeals affirmed the decision of the trial court. The deadline for Plaintiffs to appeal the case to the Ohio Supreme Court has expired, and no appeal was filed.

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.

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 450-staffed 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 opened in July 2018, two new outpatient centers in the surrounding Akron area and replacement of Akron General's electronic medical records system in the third quarter of 2017 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 healthcare 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 April 2018, the Clinic through a subsidiary became the sole member of Union Hospital located in Dover, Ohio. Union Hospital operates a hospital and several off-campus satellite services. Union Hospital has more than 100 patient beds, 300 healthcare providers on staff, and 1,100 employees. In addition to Union Hospital, Union Hospital operates Tuscarawas Ambulatory Surgery Center and Union Physician Services, a hospital-owned physician network with several offices and approximately 30 providers.

All services, programs and locations managed and operated by Union Hospital are continuing as the organizations begin the integration process. The integration process will examine the operating processes and procedures at the various entities and look for ways to improve the quality and delivery of care. The Clinic previously 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 approximately 130 miles north of Weston, selected the Clinic as its potential acquisition partner. On February 22, 2018 the Clinic and IRMC entered into a non-binding letter of intent that outlines plans for IRMC to join the System. 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, located in Southeast Florida approximately 100 miles north of Weston, 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.

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 into an advanced healthcare facility that is expected to open in early 2021. For a description of the London hospital project, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

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 364-staffed bed hospital offering critical and acute care services that opened in March 2015.

In 2017, the Clinic established Cleveland Clinic Connected, an international program that aims to improve patient care delivery around the world by enabling international health care providers to access the Clinic's best practices. The Clinic entered into its first Cleveland Clinic Connected relationship with Luye Medical Group for the general hospital in the Shanghai New Hong Qiao International Medical Center currently under development in Shanghai, China. Patients will experience the same model of care through the Clinic's collaboration and guidance in the areas of quality and patient safety, best practices and guidelines for patient care and engagement, distance health and second opinions, clinical and executive education and continuous improvements as well as the provision of advisory services across a spectrum of clinical and non-clinical areas.

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

Cleveland, Ohio Skyline

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 Care, a unit created to better enable healthcare providers and teams to take care of patient populations. Cleveland Clinic Community Care 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. Since the inception of the program in 2014, management estimates that Care Affordability initiatives and other localized efforts enabled approximately $1 billion 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 developing 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.

Beachwood Family Health Center
Beachwood, Ohio

COMMUNITY BENEFIT

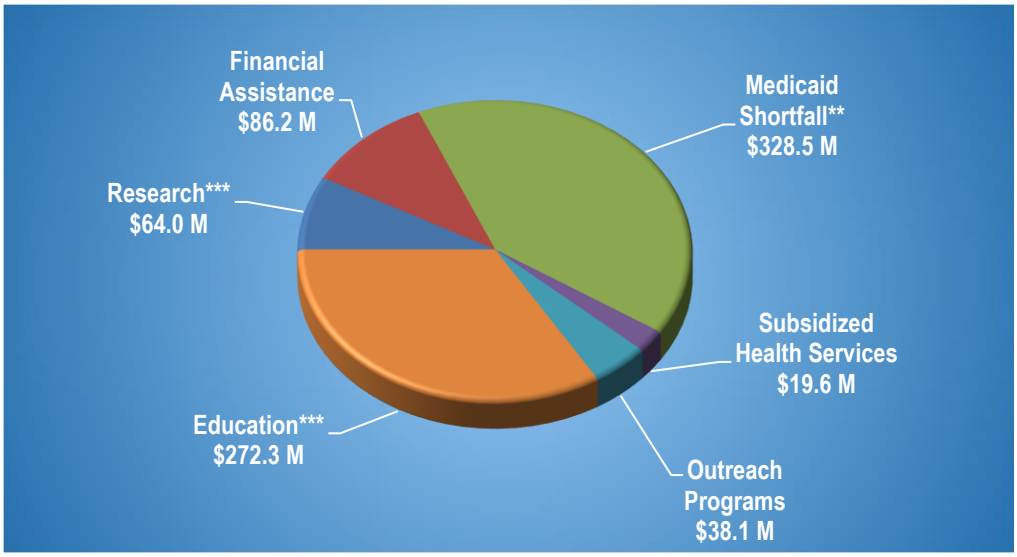
Community Benefit

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.

In 2016, the System provided $808.7 million in benefits to the communities it serves. Community benefit information for 2017 was not available at the time of issuance of this Management Discussion and Analysis. The following chart summarizes community benefits for the System:

Cleveland Clinic Health System*
Breakdown of Community Benefit (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).

Lou Ruvo Center for Brain Health
Las Vegas, Nevada

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 is 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 (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 healthcare;
- 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).

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 52,000 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 healthcare 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. In 2018, the Clinic won the Top 25 Environmental Excellence Award for the fourth straight year. This award recognizes healthcare facilities that exemplify environmental excellence and are setting the highest standards for environmental practices in healthcare. Award winners are chosen from hospitals that have the highest scores using Practice Greenhealth's thorough scoring and evaluation system. The Clinic was also recognized for being in the top ten in the nation in four Circles of Excellence: Green Building, Greening the OR, Climate and Leadership. The Leadership Circle represents the high-performing hospitals that have a strong infrastructure supporting a long term commitment to healthier environments through leadership vision, committee structure, reporting, data tracking, communication and education. Other System entities and facilities were honored with additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in healthcare sustainability in 2018.

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.

In 2018, the Clinic's Center for Functional Medicine suite located on the Clinic's main campus achieved WELL certification, a new building standard that integrates human health into building design and operation. The WELL Certification process involves rigorous testing and a final evaluation carried out by the Green Business Certification Inc., which is the third-party certification body for the WELL Building Standard. WELL certification focuses on seven main concepts: air quality, water quality, healthy foods, light quality, integration of fitness, comfortable and productive workspaces, cognitive and emotional health and support for innovative features that impact the interaction between building and human health. The Center for Functional Medicine is one of the first medical offices to be awarded this certification.

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 2007, 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 a diverse population of caregivers and patients. Its programs include cultural competence training, diversity councils, employee resource groups, language enrichment, consultation, and internally and externally focused pipeline development programs.

In 2018, the System was ranked number six on the list of the country's top eleven healthcare organizations for diversity management practices by DiversityInc. The System has made this list for the ninth 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 "2018 Leader in LGBTQ Healthcare Equality," by the Human Rights Campaign for the fourth consecutive year. 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 2018, the System was named one of the Top 50 STEM Workplaces by the American Indian Science and Engineering Society for the sixth consecutive year and 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

The System maintains a multi-phase enterprise risk management (ERM) process to develop a 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. The most recent comprehensive evaluation of top risks was concluded in the third quarter of 2016. Following this evaluation of top risks extensive risk assessments and mitigation analyses have been prepared 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 process. 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. There were no changes in internal controls over financial reporting during the six months ended June 30, 2018 that have materially affected, or are likely to materially affect, the internal controls over financial reporting for the System.

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 April 2018, Moody's preliminary financial data showed that the nonprofit hospital median operating cash flow decreased from 9.5% for fiscal year 2016 to 8.1% for fiscal year 2017. This is the lowest level seen since the 2008/2009 recession. Overall, the preliminary financial data for fiscal year 2017 is in line with the agency's negative outlook on the nonprofit healthcare and hospital sector.

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 anticipate, and remains alert to, changes in the healthcare market and is committed to formulating and implementing financial and strategic plans necessary to meet the System's strategic objectives and to enable the System to remain a recognized world leader in healthcare. To that end, System management continually monitors the environment in which it operates and evaluates the ways in which it conducts business.

PATIENT VOLUMES

The following table summarizes patient volumes for the System. The table includes Union Hospital activity beginning April 1, 2018, and includes pro froma corresponding periods for 2017 for comparative purposes:

Utilization Statistics

	For the quarter ended June 30				For the six months ended June 30			
	2018	2017	Variance	%	2018	2017	Variance	%
Inpatient admissions[(1)]								
Acute admissions	43,180	43,836	-656	-1.5%	84,784	86,873	-2,089	-2.4%
Post-acute admissions	2,822	3,022	-200	-6.6%	5,449	6,033	-584	-9.7%
	46,002	46,858	-856	-1.8%	90,233	92,906	-2,673	-2.9%
Patient days[(1)]								
Acute patient days	223,297	224,877	-1,580	-0.7%	446,823	448,103	-1,280	-0.3%
Post-acute patient days	19,916	25,042	-5,126	-20.5%	39,667	49,988	-10,321	-20.6%
	243,213	249,919	-6,706	-2.7%	486,490	498,091	-11,601	-2.3%
Surgical cases								
Inpatient	15,401	16,049	-648	-4.0%	31,087	31,829	-742	-2.3%
Outpatient	39,410	40,132	-722	-1.8%	75,991	78,489	-2,498	-3.2%
	54,811	56,181	-1,370	-2.4%	107,078	110,318	-3,240	-2.9%
Emergency department visits	170,020	173,543	-3,523	-2.0%	330,443	334,613	-4,170	-1.2%
Observations	15,380	15,615	-235	-1.5%	30,486	31,223	-737	-2.4%
Clinic outpatient evaluation and management visits	1,131,052	1,113,965	17,087	1.5%	2,271,717	2,245,241	26,476	1.2%

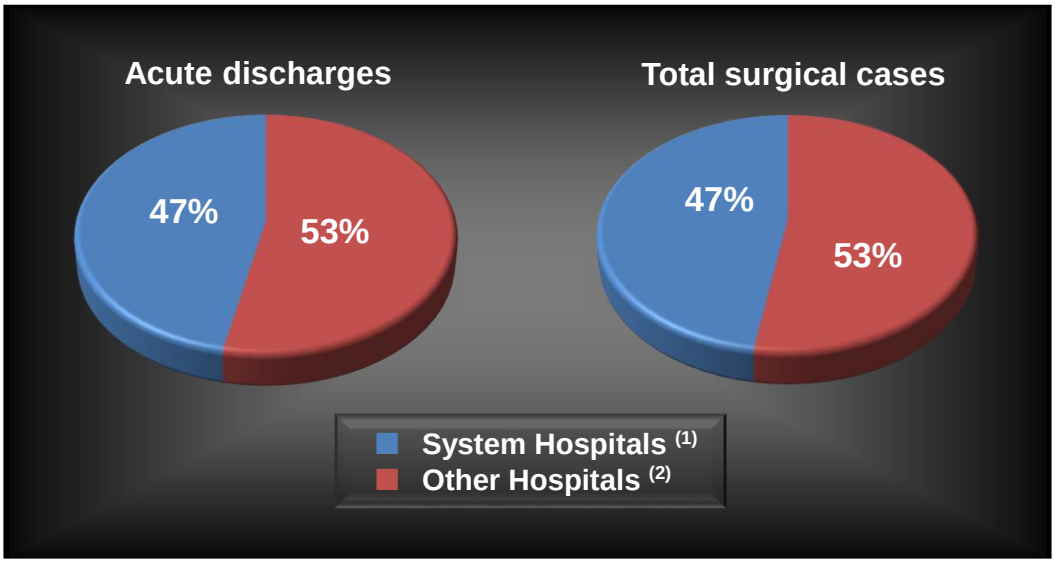
[(1)] Excludes newborns

Inpatient acute admissions for the System decreased 2% in both the second quarter of 2018 and the first six months of 2018 compared to the same period in 2017. In the first six months of 2018, acute admissions in the Cleveland metro area decreased 2%. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio

service area were flat in the first six months of 2018 compared to the same period in 2017. Akron General and Union Hospital also experienced a decrease in acute admissions in the first six months of 2018 compared to the same period in 2017, while the Florida facilities experienced a 1% increase in acute admissions over the same period.

Total surgical cases for the System decreased 2% in the second quarter of 2018 and decreased 3% during the first six months of 2018 compared to the same period in 2017. For the first six months of 2018, total surgical cases in the Cleveland metro area decreased 2%. According to data from the Center for Health Affairs, total surgical cases in northeast Ohio decreased 1% in the first six months of 2018 compared to the same period in 2017. Akron General, Union Hospital and the Florida facilities also experienced decreases in total surgical cases over the same period. The surgical mix of total surgical cases for the System for the first six months of 2018 was 29% inpatient and 71% outpatient, which represents a slight shift from outpatient to inpatient compared to the surgical mix for the same period in 2017.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the six months ended June 30, 2018:



Source: The Center for Health Affairs Volume Statistics

(1) "System Hospitals" excludes Florida, Akron General, and Union Hospital 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. In 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.

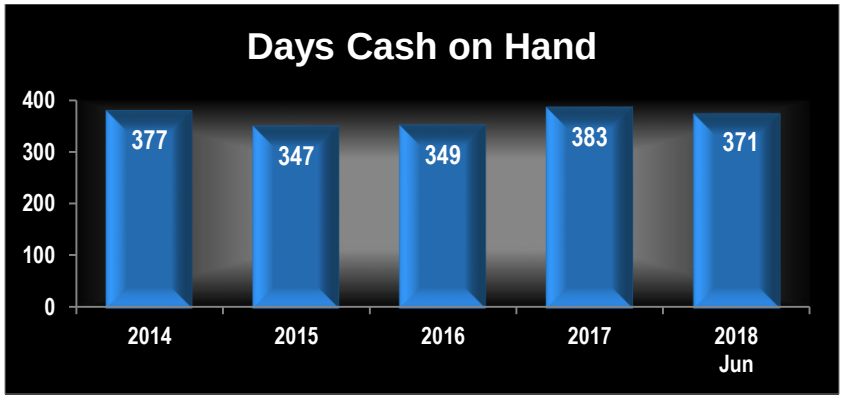
The following table sets forth the allocation of the System's cash and investments at June 30, 2018 and December 31, 2017:

Cash and Investments
(Dollars in thousands)

	June 30, 2018		December 31, 2017	
Cash and cash equivalents	$ 573,597	6%	$ 770,654	8%
Fixed income securities*	2,478,467	28%	2,412,477	27%
Marketable equity securities*	3,190,569	36%	3,192,650	35%
Alternative investments	2,738,317	30%	2,696,560	30%
Total cash and investments	$ 8,980,950	100%	$ 9,072,341	100%
Less restricted investments**	(946,372)		(1,101,417)	
Unrestricted cash and investments	$ 8,034,578		$ 7,970,924	
Days cash on hand	371		383	

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

The following chart summarizes days cash on hand for the System at December 31 for the last four years and at June 30, 2018:



At June 30, 2018, total cash and investments for the System (including restricted investments) were $8.9 billion, a decrease of $91 million from $9.1 billion at December 31, 2017. Cash inflows consist of cash provided by operating activities and related investment income of $259 million, a net increase in restricted gifts and income of $41 million, net proceeds from the issuance of long-term borrowings of $45 million, and $40 million of cash and investments received by the System from the Union Hospital member substitution business combination. Cash inflows were offset by net capital expenditures of $357 million and principal payments on debt of $117 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $164.0 million at June 30, 2018, with an asset mix of 9% cash and short-term investments, 40% fixed-income securities, 31% equity investments and 20% 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 June 30, 2018 are $49.4 million of funds held by trustees. Funds held by trustees include $49.1 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 June 30, 2018, the asset mix of funds held by trustees was 2% cash and short-term investments and 98% 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 June 30, 2018 and December 31, 2017 consist of the following:

Alternative Investments
(Dollars in thousands)

	June 30, 2018		December 31, 2017	
Hedge funds	$ 1,354,641	50%	$ 1,357,932	50%
Private equity/venture capital	909,112	33%	854,632	32%
Real estate	474,564	17%	483,996	18%
Total alternative investments	$ 2,738,317	100%	$ 2,696,560	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 losses of 0.2% for the second quarter of 2018, which is lower than the portfolio's benchmark loss of 0.1% and lower than investment gains of 1.9% experienced in the second quarter of 2017. For the first six months of 2018, the System experienced investment gains of 0.2%, which is higher than the portfolio's benchmark losses of 1.1% but lower than the investment gains of 5.8% experienced for the first six months of 2017.

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

Investment Return
(Dollars in thousands)

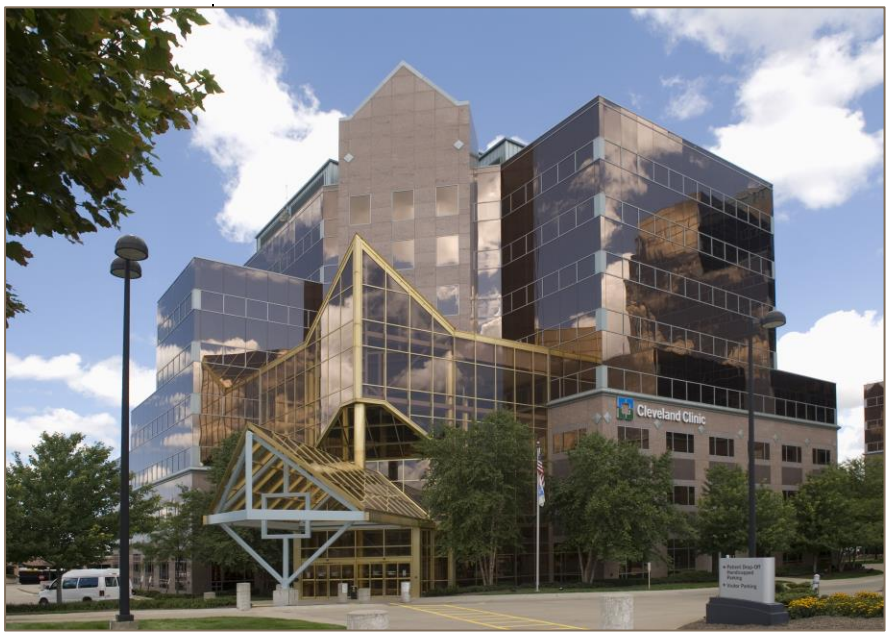
	For the quarter ended June 30		For the six months ended June 30	
	2018	2017	2018	2017
Other unrestricted revenue:				
Interest income and dividends	$ 533	$ 814	$ 1,161	$ 1,473
Nonoperating gains and losses, net:				
Interest income and dividends	21,368	19,862	36,565	34,312
Net realized gains on sales of investments	71,640	71,965	139,278	96,749
Net change in unrealized gains (losses) on investments	(138,293)	67,967	(195,163)	260,521
Equity method income on alternative investments	52,178	18,406	69,782	37,177
Investment management fees	(7,724)	(4,747)	(14,189)	(12,624)
	(831)	173,453	36,273	416,135
Other changes in net assets:				
Investment income on restricted investments and other	1	10,598	201	24,167
Total investment return (loss)	$ (297)	$184,865	$ 37,635	$441,775

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 June 30, 2018, the Plan's investments were comprised of 4% cash and cash equivalents, 48% fixed-income investments, 30% equities, and 18% alternative investments.

Long-term Debt

At June 30, 2018, outstanding bonds for the System totaled $3.293 billion, comprised of $2.574 billion (78%) of fixed-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 June 30, 2018 was $625 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.



Independence Family Health Center
Independence, Ohio

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 $353 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.

The System maintains the Cleveland Clinic Health System Obligated Group Commercial Paper Program (CP Program), which provides for the issuance of the Series 2014A CP Notes. The CP Program was established in November 2014 and will terminate no later than January 2044. 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 June 30, 2018, the System has $71.0 million of outstanding Series 2014A CP Notes.

Outstanding hospital revenue bonds for the System as of June 30, 2018 and December 31, 2017 consist of the following:

Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	June 30 2018	December 31 2017
2017A	CCHS Obligated Group	Fixed	2043	$ 818,775	$ 818,775
2017B	CCHS Obligated Group	Fixed	2043	169,255	169,255
2017C	CCHS Obligated Group	Fixed	2032	8,945	9,305
2016	CCHS Obligated Group	Fixed	2046	325,000	325,000
2016	CCHS Obligated Group	Variable	2026	16,270	16,270
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	62,650	73,150
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	61,165	61,165
2012A	CCHS Obligated Group	Fixed	2039	439,925	451,135
2011A	CCHS Obligated Group	Fixed	2032	148,645	160,605
2011B	CCHS Obligated Group	Fixed	2031	26,380	27,785
2011C	CCHS Obligated Group	Fixed	2032	157,945	157,945
2009B	CCHS Obligated Group	Fixed	2039	16,135	31,640
2008A	CCHS Obligated Group	Fixed	2043	-	7,930
2008B	CCHS Obligated Group	Variable	2043	327,575	327,575
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
				$ 3,292,685	$ 3,351,555

In August 2018 the System through a UK subsidiary entered into a private placement agreement to issue the 2018 Sterling Notes totaling £665 million. The subsidiary received £300 million in August 2018 and will receive additional proceeds on November 1, 2018 and August 1, 2019. For a description of the 2018 Sterling Notes, refer to "FINANCING DEVELOPMENTS."

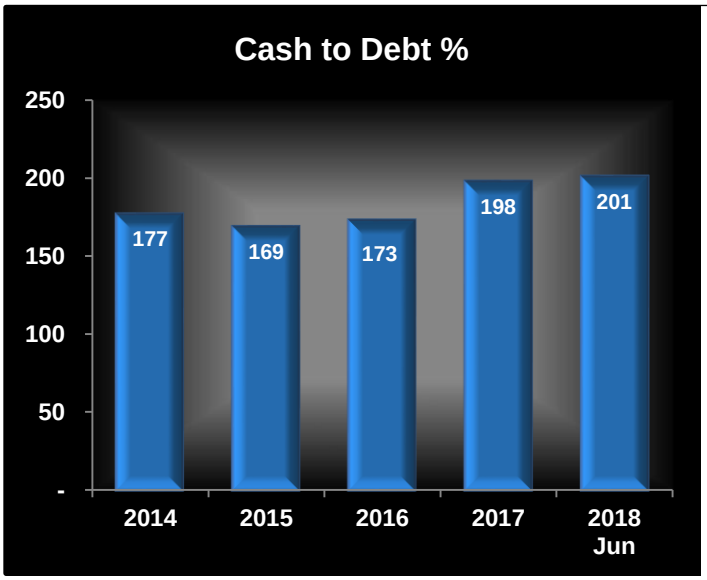
At June 30, 2018, the System has notes payable and capital leases totaling $569.8 million. Notes payable and capital leases include $376.5 million of notes payable, $105.0 million outstanding on a revolving credit facility and $88.3 million of capital lease liabilities primarily related to property and equipment.

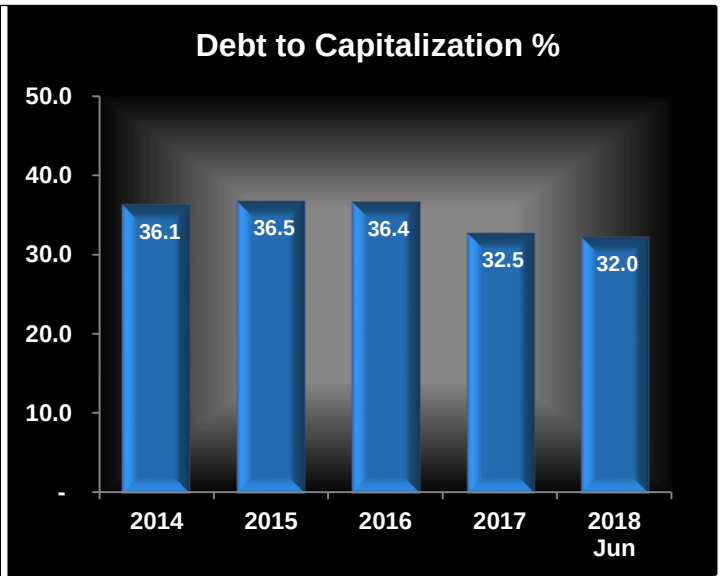
Included in notes payable at June 30, 2018 is a term loan entered into by a Clinic subsidiary with a financial institution in 2015 for a principal amount of $375 million. The proceeds of the term loan were used to finance the System's international business strategy. The term loan bore interest at a variable-rate based on the London Interbank Offered Rate (LIBOR) index plus an applicable spread. The term loan was paid off in August 2018 with the proceeds of the 2018 Sterling Notes.

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 annually for a one-year period. 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 June 30, 2018 and December 31, 2017 totaled $105.0 million and $60.0 million, respectively, and are recorded in notes payable in the consolidated balance sheets. The System drew $45.0 million in the second quarter of 2018 to extinguish debt that was assumed in the Union Hospital member substitution.

The following charts summarize cash-to-debt and debt-to-capitalization ratios for the System at December 31 for the last four years and at June 30, 2018:





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 July 2018, Moody's and S&P affirmed their respective ratings and outlooks. According to reports issued by Moody's and S&P, the ratings reflect a unique and strong enterprise profile, a strong leadership team and a national and international clinical reputation.

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 June 30, 2018 and 2017

The following narrative describes the consolidated results of operations for the System for the second quarters of 2018 and 2017. The consolidated results of operations for the second quarter of 2018 includes the financial operations of Union Hospital, which became a consolidated entity of the System in April 2018. Union Hospital comprised approximately 1.4% of total consolidated operating revenues and 1.6% of total consolidated operating expenses in the second quarter of 2018. No adjustments have been made in the following narrative to exclude Union Hospital operations except where indicated as same facility basis, which excludes

Union Hospital activity in the second quarter of 2018 for comparative purposes.

Operating income for the System in the second quarter of 2018 was $25.1 million, resulting in an operating margin of 1.1%, as compared to operating income of $130.5 million and an operating margin of 6.0% in the second quarter of 2017. The lower operating income resulted from a 7.3% increase in operating expenses, which outpaced total unrestricted revenue growth of 2.0% in the same period. Operating income in the second quarter of 2017 benefited from a one-time $70.0 million non-patient payment from a payor. Excluding the one-time payment, total unrestricted revenues increased 5.4%. Nonoperating gains for the System were $55.6 million in the second quarter of 2018 compared to nonoperating gains of $172.8 million in the second quarter of 2017. The decrease from the prior year was primarily due to changes in the financial markets. Overall, the System reported an excess of revenues over expenses of $80.7 million in the second quarter of 2018 compared to an excess of revenues over expenses of $303.3 million in the second quarter of 2017.

The System's net patient service revenue increased $106.6 million (5.7%) in the second quarter of 2018 compared to the same period in 2017. The System experienced a decrease in same facility inpatient acute admissions of 1.2%. However, the impact to patient service revenue was mitigated by a strong case mix due to efforts that focused on accurate documentation of patient care and higher acuity patients, which has resulted in more inpatient revenue per patient. Same facility total surgical cases and emergency department visits were lower in the second quarter of 2018 compared to the second quarter of 2017 by 2.0% and 2.0%, respectively, while outpatient evaluation and management visits increased 1.5% over the same period. The System has also experienced an increase in Medicare revenue primarily as a result of the growing senior citizen population as people are aging into the Medicare program and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 1.4% in the second quarter of 2018 compared to the same period in 2017. 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 2018. 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.

Other unrestricted revenues decreased $62.9 million (22.1%) in the second quarter of 2018 compared to the same period in 2017. The decrease in other unrestricted revenues was primarily due to a one-time $70.0 million non-patient payment from a provider received from a payor in the second quarter of 2017. This decrease was offset by a $7.9 million increase in outpatient pharmacy revenue.

Total operating expenses increased $149.1 million (7.3%) in the second quarter of 2018 compared to the same period in 2017. Excluding Union Hospital expenses in the second quarter of 2018, total operating expenses increased $115.0 million (5.7%) compared to the same period in 2017. 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 $67.2 million (5.8%) in the second quarter of 2018 compared to the same period in 2017. Salaries, excluding benefits, increased $62.9 million (6.3%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2018 and a 2.5% increase in same facility average full-time equivalent employees in the second quarter of 2018 compared to the same period in 2017. Benefit costs increased $4.3 million (2.6%) during the same period. The System experienced a $3.8 million increase in defined contribution expenses and a $3.8 million increase in FICA expenses primarily due to the increase in salaries and full-time equivalent employees. These increases were offset by a $0.7 million decrease in employee healthcare costs primarily due to a shift in healthcare services from external providers to providers within the System.

Supplies expense increased $14.4 million (7.2%) in the second quarter of 2018 compared to the same period in 2017. The System experienced a $9.4 million increase in implantables and other medical supplies and a $5.0 million increase in non-medical supplies primarily due to increased minor equipment purchases and dietary expenses.

Pharmaceutical costs increased $37.9 million (16.2%) in the second quarter of 2018 compared to the same period in 2017. 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 $8.4 million in the second quarter of 2018 compared to the same period in 2017. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $8.9 million (6.7%) in the second quarter of 2018 compared to the same period in 2017. The System experienced a $10.0 million increase in purchased non-medical service costs primarily related to $6.2 million increase in software and hardware technology costs and other various costs associated with certain System projects and initiatives. This increase was offset by a $1.1 million decrease in purchased medical services primarily related to external lab services.

Administrative services increased $7.3 million (15.0%) in the second quarter of 2018 compared to the same period in 2017. The increase in administrative services was primarily due to consulting fees and professional services for certain System projects and initiatives.

Facilities expense increased $10.1 million (12.8%) in the second quarter of 2018 compared to the same period in 2017. The increase in facilities expense was primarily due to a $5.3 million increase in repairs and maintenance expenses, a $3.1 million increase in utility costs and a $1.9 million increase in rent expenses.

Insurance expense increased $1.8 million (8.6%) in the second quarter of 2018 compared to the same period in 2017. The increase in insurance expense was primarily due to a $2.5 million insurance settlement accrual recorded in 2018 offset by a $0.8 million decrease in professional

malpractice expense based on actuarial estimates of expected loss claims for each period. 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 $1.2 million (3.4%) in the second quarter of 2018 compared to the same period in 2017. The decrease is primarily due 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. The System has also made $72.4 million of net principal payments on bonds, notes and capital leases in 2018 that has reduced the amount of outstanding debt.

Depreciation and amortization expenses increased $3.2 million (2.6%) in the second quarter of 2018 compared to the same period in 2017. Changes in depreciation include property, plant and equipment that was fully depreciated in 2017, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2018.

Special charges decreased $0.5 million (33.1%) in the second quarter of 2018 compared to the same period in 2017. The System incurred and recorded $0.9 million and $1.4 million of special charges in the second quarters of 2018 and 2017, 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.

Entrance to first Cleveland Clinic Hospital Building - 1924

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 $55.6 million in the second quarter of 2018 compared to a net gain of $172.8 million in the second quarter of 2017, resulting in an unfavorable variance of $117.2 million. Investment returns were unfavorable by $174.3 million in the second quarter of 2018 compared to the same period in 2017. The System's long-term investment portfolio reported investment losses of 0.2% for the second quarter of 2018, which is lower than the portfolio's benchmark loss of 0.1% and lower than investment gains of 1.9% experienced in the second quarter of 2017. Derivative gains and losses were favorable by $11.9 million in the second quarter of 2018 compared to the same period in 2017. 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. Other nonoperating gains and losses were favorable by $45.1 million in the second quarter of 2018 compared to the same period in 2017 primarily due to a $52.3 million Union Hospital member substitution contribution recorded in the second quarter of 2018 offset by a $6.7 million unfavorable 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 Six Months Ended June 30, 2018 and 2017

The following narrative describes the consolidated results of operations for the System for the first six months of 2018 and 2017. The consolidated results of operations for the first six months of 2018 includes the financial operations of Union Hospital, which became a consolidated entity of the System in April 2018. Union Hospital comprised approximately 0.7% of total consolidated operating revenues and 0.8% of total consolidated operating expenses in the first six months of 2018. No adjustments have been made in the following narrative to exclude Union Hospital operations except where indicated as same facility basis, which excludes Union Hospital activity in the first six months of 2018 for comparative purposes.

Operating income for the System in the first six months of 2018 was $72.7 million, resulting in an operating margin of 1.7%, as compared to operating income of $191.2 million and an operating margin of 4.5% in the first six months of 2017. The lower operating income resulted from a 5.3% increase in operating expenses, which outpaced total unrestricted revenue growth of 2.3% in the same period. Operating income in the first six months of 2017 benefited from a one-time $70.0 million non-patient payment from a payor. Excluding the one-time payment, total unrestricted revenues increased 4.0%. Nonoperating gains for the System were $114.5 million in the first six months of 2018 compared to nonoperating gains of $420.7 million in the first six months of 2017. The decrease from the prior year was primarily due to changes in the financial markets. Overall, the System reported an excess of revenues over expenses of $187.2 million in the first six months of 2018 compared to an excess of revenues over expenses of $611.8 million in the first six months of 2017.

The System's net patient service revenue increased $147.1 million (3.9%) in the first six months of 2018 compared to the same period in 2017. The System experienced a decrease in same facility inpatient acute admissions of 2.3%. However, the impact to patient service revenue

was mitigated by a strong case mix due to efforts that focused on accurate documentation of patient care and higher acuity patients, which has resulted in more inpatient revenue per patient. Same facility total surgical cases and emergency department visits were lower in the first six months of 2018 compared to the first six months of 2017 by 2.7% and 1.2%, respectively, while outpatient evaluation and management visits increased 1.2% over the same period. The System has also experienced an increase in Medicare revenue primarily as a result of the growing senior citizen population as people are aging into the Medicare program and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 1.1% in the first six months of 2018 compared to the same period in 2017. 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 2018. 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.

Other unrestricted revenues decreased $49.8 million (10.3%) in the first six months of 2018 compared to the same period in 2017. The decrease in other unrestricted revenues was primarily due to a one-time $70.0 million non-patient payment from a provider received from a payor in the first six months of 2017. This decrease was offset by a $17.9 million increase in outpatient pharmacy revenue and a $5.6 million increase in unrestricted gifts and assets released from restriction primarily related to the receipt of unrestricted pledge payments.

Total operating expenses increased $215.8 million (5.3%) in the first six months of 2018 compared to the same period in 2017. Excluding Union Hospital expenses in the first six months of 2018, total operating expenses increased $181.7 million (4.5%) compared to the same period in 2017. 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 $93.2 million (4.0%) in the first six months of 2018 compared to the same period in 2017. Salaries, excluding benefits, increased $96.4 million (4.9%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2018 and a 2.4% increase in same facility average full-time equivalent employees in the first six months of 2018 compared to the same period in 2017. Benefit costs decreased $3.2 million (0.9%) during the same period. The System experienced an $11.1 million decrease in employee healthcare costs primarily due to a shift in healthcare services from external providers to providers within the System. This decrease was offset by a $7.2 million increase in defined contribution expenses and a $6.5 million increase in FICA expenses primarily due to the

increase in salaries and full-time equivalent employees.

Supplies expense increased $24.0 million (6.1%) in the first six months of 2018 compared to the same period in 2017. The System experienced a $18.0 million increase in implantables and other medical supplies and a $6.0 million increase in non-medical supplies primarily due to increased minor equipment purchases and dietary expenses.

Pharmaceutical costs increased $68.5 million (15.0%) in the first six months of 2018 compared to the same period in 2017. 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 $17.5 million in the first six months of 2018 compared to the same period in 2017. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $11.1 million (4.3%) in the first six months of 2018 compared to the same period in 2017. The System experienced a $17.0 million increase in purchased non-medical service costs primarily related to $10.4 million increase in software and hardware technology costs and other various costs associated with certain System projects and initiatives. This increase was offset by a $5.9 million decrease in purchased medical services primarily related to external lab services.

Administrative services increased $3.2 million (3.5%) in the first six months of 2018 compared to the same period in 2017. The increase in administrative services was primarily due to consulting fees and professional services for certain System projects and initiatives.

Facilities expense increased $12.0 million (7.4%) in the first six months of 2018 compared to the same period in 2017. The increase in facilities expense was primarily due to a $7.1 million increase in repairs and maintenance expenses, a $4.8 million increase in utility costs and a $2.5 million increase in rent expenses. These increases were offset by a $1.6 million decrease in facility costs at Grosvenor Place related to costs incurred before the building was vacated in early 2017.

Insurance expense increased $1.5 million (3.7%) in the first six months of 2018 compared to the same period in 2017. The increase in insurance expense was primarily due to a $2.5 million insurance settlement accrual recorded in 2018 offset by a $1.3 million decrease in professional malpractice expense based on actuarial estimates of expected loss claims for each period. 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 $4.4 million (6.1%) in the first six months of 2018 compared to the same period in 2017. The decrease is primarily due 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. The System has also made $72.4 million of net principal payments on bonds, notes and capital leases in 2018 that has reduced the amount of outstanding debt.

Depreciation and amortization expenses increased $8.4 million (3.4%) in the first six months of 2018 compared to the same period in 2017. Changes in depreciation include property, plant and equipment that was fully depreciated in 2017, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2018.

Special charges decreased $1.6 million (47.2%) in the first six months of 2018 compared to the same period in 2017. The System incurred and recorded $1.8 million and $3.4 million of special charges in the first six months of 2018 and 2017, 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.

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 $114.5 million in the first six months of 2018 compared to a net gain of $420.7 million in the first six months of 2017, resulting in an unfavorable variance of $306.2 million. Investment returns were unfavorable by $379.9 million in the first six months of 2018 compared to the same period in 2017. The System's long-term investment portfolio reported investment gains of 0.2% for the first six months of 2018, which is higher than the portfolio's benchmark loss of 1.1% but lower than investment gains of 5.8% experienced in the first six months of 2017. Derivative gains and losses were favorable by $25.3 million in the first six months of 2018 compared to the same period in 2017. 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. Other nonoperating gains and losses were favorable by $48.4 million in the first six months of 2018 compared to the same period in 2017 primarily due to a $52.3 million Union Hospital member substitution contribution recorded in the second quarter of 2018 offset by a $3.3 million unfavorable 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.

BALANCE SHEET – JUNE 30, 2018 COMPARED TO DECEMBER 31, 2017

Patient accounts receivable increased $96.5 million (9.5%) from December 31, 2017 to June 30, 2018. The increase in patient receivables is partially due to the increase in net patient service revenue resulting from rate increases on the System's managed care contracts that became effective in January 2018. Union Hospital member substitution transaction added approximately $20.9 million of patient accounts receivable to the balance sheet. The System has also 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. Patient responsibility accounts receivable also tend to be seasonally higher in the first quarter as many insurance plans have annual deductible requirements. The System has various initiatives to enhance cash collection efforts and create efficiencies in the revenue cycle process, including the implementation of EAPM. EAPM was implemented at the Clinic in 2016 and at four other System hospitals in 2017. Five additional System hospitals have implemented or will be implementing EAPM in 2018. Days revenue outstanding for the System increased from 49 days at December 31, 2017 to 51 days at June 30, 2018.

Investments for current use decreased $103.9 million (67.1%) from December 31, 2017 to June 30, 2018. Investments for current use includes funds held by the bond trustee that are used to pay current debt service payments. The System paid $103.9 million in debt service payments in January 2018 that had been funded to the bond trustee in 2017. There were no funds held by the bond trustee reported in investment for current use at June 30, 2018. Investments for current use also includes assets held for self-insurance that will be used to pay the current portion of estimated claim liabilities. There was no change in these investments in the first six months of 2018.

Other current assets increased $25.1 million (6.7%) from December 31, 2017 to June 30, 2018. The increase in other current assets was primarily due to a $31.5 million increase in prepaid expenses driven by annual maintenance and insurance contracts and a $10.6 million increase in international management fee receivables offset by the collection of various receivables that had been recorded in a prior period

Unrestricted long-term investments increased $45.1 million (0.6%) from December 31, 2017 to June 30, 2018. The increase was primarily due to a $50.0 million dividend received from the System's captive insurance subsidiary, $37.4 million added to the balance sheet as a result of Union Hospital member substitution transaction and $20.0 million of interest rate swap collateral returned to the System. Capital expenditures totaled $356.6 million in the first six months of 2018, which was partially offset by positive cash provided by operating activities and net nonoperating gains and losses. The System's long-term investment portfolio experienced slightly positive results for the first six months of 2018.

Funds held by trustees decreased $19.8 million (28.6%) from December 31, 2017 to June 30, 2018. The decrease in funds held by trustees is primarily due to a $20.0 million decrease in collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance decreased $46.8 million (29.3%) from December 31, 2017 to June 30, 2018. The decrease in self-insurance assets is primarily due to the payment of a $50.0 million dividend from the System's captive insurance subsidiary to the Clinic. The dividend was declared in 2017. This decrease was offset by investment gains experienced in the System's captive insurance subsidiary and premiums received by the captive insurance subsidiary.

Donor restricted assets increased $15.5 million (2.2%) from December 31, 2017 to June 30, 2018. 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 $130.4 million (2.8%) from December 31, 2017 to June 30, 2018. The System had net expenditures for property, plant and equipment of $356.6 million, offset by depreciation expense of $254.0 million, which includes $1.6 million of accelerated depreciation expense recorded in special charges. The System also acquired $41.2 million of property, plant and equipment in Union Hospital member substitution transaction and $0.5 million of donated capital. These increase were partially offset by $7.7 million of foreign currency translation losses. Capital expenditures in 2018 include amounts paid on retainage liabilities recorded at December 31, 2017 and exclude assets acquired through capital leases and other financing arrangements. Retainage liabilities decreased $13.3 million, and new capital leases and other financing arrangements totaled $7.2 million. 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 decreased $11.9 million (1.7%) from December 31, 2017 to June 30, 2018. The decrease in noncurrent assets was primarily due to a $35.6 million reduction in receivables related to joint fundraising efforts by the Clinic and CWRU for the health education campus offset by perpetual trusts valued at $12.9 million acquired in Union Hospital member substitution transaction and a $4.9 million increase in long-term pledge receivables.

Accounts payable decreased $54.4 million (10.8%) from December 31, 2017 to June 30, 2018. The decrease in accounts payable was primarily attributable to the timing of payment processing for trade payables, a $13.3 million decrease in retainage liabilities on current construction projects and an $8.9 million decrease in outstanding checks.

Compensation and amounts withheld from payroll increased $48.1 million (13.9%) from December 31, 2017 to June 30, 2018. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $2.3 million (0.5%) from December 31, 2017 to June 30, 2018. The System reclassified regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments made in the first six months of 2018.

Variable rate debt classified as current decreased $75.4 million from December 31, 2017 to June 30, 2018. Long-term debt classified as current consists of variable-rate bonds supported by the System's self-liquidity program and bonds with letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds. The decrease in variable rate debt classified as current is due to the reclassification of debt from current to long-term resulting from the renewal of a standby bond purchase agreement supporting the Series 2013B bonds that was previously set to expire in 2018.

Other current liabilities increased $6.3 million (1.4%) from December 31, 2017 to June 30, 2018. The increase in other current liabilities is primarily due to a $6.2 million increase in accrued interest payable related to bonds that pay

interest semi-annually in January and July of each year and a $5.0 million increase in self-insurance general liability accruals. These increases were offset by a $14.4 million decrease in deferred revenue related to the international management contracts.

Hospital revenue bonds increased $10.5 million (0.4%) from December 31, 2017 to June 30, 2018. The increase is primarily due to the reclassification of variable rate debt classified as current to long-term related to the renewal of a standby bond purchase agreement offset by the reclassification of regularly scheduled principal payments from long-term to current for bond payments due within one year.

Notes payable and capital leases increased $39.5 million (29.3%) from December 31, 2017 to June 30, 2018. In June 2018, the System drew an additional $45.0 million on its revolving credit facility for the purpose of extinguishing Union Hospital bonds that were acquired in the Union Hospital member substitution transaction. The System also entered into $7.2 million in new capital leases in the first six months of 2018 offset by the reclassification regularly scheduled principal payments from long-term to current and a $2.6 million reduction in capital leases related to an early lease buyout payment on a capital lease.

Professional and general insurance liability reserves decreased $6.6 million (4.4%) from December 31, 2017 to June 30, 2018. The decrease is due to claim liability payments in excess of expenses recorded for the accrual of current year claim estimates.

Accrued retirement benefits decreased $8.7 million (1.8%) from December 31, 2017 to June 30, 2018. The change in accrued retirement benefits is comprised of a $9.7 million decrease in the System's defined benefit pension plan liabilities and a $1.0 million increase in other postretirement benefit liabilities. The decrease in defined benefit pension plan liabilities was primarily due to net periodic benefit, which is based on actuarial estimates resulting from the expected return on plan assets in excess of interest cost incurred on plan obligations.

Other noncurrent liabilities decreased $25.9 million (4.6%) from December 31, 2017 to June 30, 2018. The decrease in other noncurrent liabilities is primarily due to a $27.1 million decrease in derivative liabilities associated with changes in the fair value of the System's interest rate swap derivative contracts.

Total net assets increased $212.9 million (2.3%) from December 31, 2017 to June 30, 2018. Unrestricted net assets increased $176.6 million (2.1%) primarily due to an excess of revenues over expenses of $187.2 million and donated capital and assets released from restriction for capital purposes of $1.5 million offset by foreign currency translation losses of $9.8 million and retirement benefits adjustment of $1.4 million. Temporarily restricted net assets increased $15.0 million (2.3%), primarily due to $39.0 million in temporarily restricted gifts offset by $24.5 million in assets released from restrictions for operations and capital purposes. Permanently restricted net assets increased $21.2 million (6.3%) primarily due to $7.4 million of permanently restricted gifts and $12.9 million of perpetual trusts acquired in Union Hospital member substitution transaction.

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.