Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended March 31, 2019

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	March 31 2019	December 31 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 312,968	$ 444,763
Patient receivables	1,323,349	1,122,918
Investments for current use	53,841	53,841
Other current assets	504,956	426,465
Total current assets	2,195,114	2,047,987
Investments:		
Long-term investments	7,993,115	7,533,668
Funds held by trustees	84,187	49,377
Assets held for self-insurance	119,586	106,966
Donor restricted assets	819,840	744,851
	9,016,728	8,434,862
Property, plant, and equipment, net	5,677,549	5,072,464
Other assets:		
Pledges receivable, net	161,057	152,448
Trusts and interests in foundations	107,830	87,606
Other noncurrent assets	833,355	411,762
	1,102,242	651,816
Total assets	$ 17,991,633	$ 16,207,129

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	March 31 2019	December 31 2018
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 480,807	$ 527,672
Compensation and amounts withheld from payroll	443,494	359,342
Current portion of long-term debt	206,717	191,350
Variable rate debt classified as current	375,146	407,776
Other current liabilities	478,423	493,453
Total current liabilities	1,984,587	1,979,593
Long-term debt	3,831,531	3,558,911
Other liabilities:		
Professional and general insurance liability reserves	163,034	141,182
Accrued retirement benefits	510,693	465,527
Other noncurrent liabilities	936,903	542,029
	1,610,630	1,148,738
Total liabilities	7,426,748	6,687,242
Net assets:		
Without donor restrictions	9,390,301	8,465,468
With donor restrictions	1,174,584	1,054,419
Total net assets	10,564,885	9,519,887
Total liabilities and net assets	$ 17,991,633	$ 16,207,129

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended March 31	
	2019	2018
Unrestricted revenues		
Net patient service revenue	$ 2,282,885	$ 1,909,774
Other	239,454	212,677
Total unrestricted revenues	2,522,339	2,122,451
Expenses		
Salaries, wages, and benefits	1,411,157	1,183,220
Supplies	249,220	203,199
Pharmaceuticals	301,899	254,225
Purchased services and other fees	164,615	128,260
Administrative services	49,224	39,977
Facilities	95,769	85,230
Insurance	25,234	19,874
	2,297,118	1,913,985
Operating income before interest, depreciation, amortization, and special charges	225,221	208,466
Interest	39,751	33,001
Depreciation and amortization	149,268	127,055
Operating income before special charges	36,202	48,410
Special charges	0	834
Operating income	36,202	47,576
Nonoperating gains and losses		
Investment return	371,640	37,104
Derivative (loss) income	(8,487)	15,416
Other, net	520,021	6,376
Net nonoperating gains and losses	883,174	58,896
Excess of revenues over expenses	919,376	106,472

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

($ in thousands)

Changes in Net Assets

	Three Months Ended March 31	
	2019	2018
Changes in net assets without donor restrictions:		
Excess of revenues over expenses	$ 919,376	$ 106,472
Net assets released from restriction for capital purposes	3,647	597
Retirement benefits adjustment	1,323	(715)
Foreign currency translation	457	13,000
Other	30	50
Increase in net assets without donor restrictions	924,833	119,404
Changes in net assets with donor restrictions:		
Gifts and bequests	35,470	25,209
Net investment income	26,008	200
Net assets released from restrictions used for operations included in other unrestricted revenues	(9,088)	(13,451)
Net assets released from restriction for capital purposes	(3,647)	(597)
Change in interests in foundations	1,008	-
Change in value of perpetual trusts	(582)	630
Member substitution contribution	70,988	-
Other	8	(11)
Increase in net assets with donor restrictions	120,165	11,980
Increase in net assets	1,044,998	131,384
Net assets at beginning of year	9,519,887	9,343,453
Net assets at end of period	$ 10,564,885	$ 9,474,837

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31	
	2019	2018
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 1,044,998	$ 131,384
Adjustments to reconcile increase in net assets to net cash (used in) provided by operating activities and net nonoperating gains and losses:		
Retirement benefits adjustment	(1,323)	715
Net realized and unrealized gains on investments	(384,703)	(27,320)
Depreciation and amortization	149,268	127,852
Foreign currency translation gain	(457)	(13,000)
Restricted gifts, bequests, investment income, and other	(61,904)	(26,039)
Accreted interest and amortization of bond premiums	(1,458)	(1,545)
Net loss (gain) in value of derivatives	5,060	(19,843)
Member substitution contribution	(590,168)	-
Changes in operating assets and liabilities:		
Patient receivables	(92,967)	(56,878)
Other current assets	(44,986)	21
Other noncurrent assets	(355,641)	710
Accounts payable and other current liabilities	(52,573)	(49,545)
Other liabilities	363,687	(17,004)
Net cash (used in) provided by operating activities and net nonoperating gains and losses	(23,167)	49,508
Financing activities		
Proceeds from long-term borrowings	2,624	-
Principal payments on long-term debt	(101,905)	(66,998)
Change in pledges receivables, trusts and interests in foundations	3,274	(3,986)
Restricted gifts, bequests, investment income, and other	61,904	26,039
Net cash used in financing activities	(34,103)	(44,945)
Investing activities		
Expenditures for property and equipment, net	(146,660)	(158,554)
Net change in cash equivalents reported in long-term investments	9,005	74,796
Purchases of investments	(1,903,378)	(432,419)
Sales of investments	1,946,347	479,952
Member substitution cash contribution	16,397	-
Net cash used in by investing activities	(78,289)	(36,225)
Effect of exchange rate changes on cash	3,764	(403)
Decrease in cash and cash equivalents	(131,795)	(32,065)
Cash and cash equivalents at beginning of year	444,763	241,227
Cash and cash equivalents at end of period	$ 312,968	$ 209,162

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, 2018.

2. Organization and Consolidation

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

The System is the leading provider of healthcare services in northeast Ohio. As of March 31, 2019, the System operates 18 hospitals with approximately 4,900 staffed beds. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by the Clinic. The System operates 21 outpatient family health centers, 11 ambulatory surgery centers, as well as numerous physician offices, which are located throughout northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In Florida, the System operates 5 hospitals and a clinic located throughout Southeast Florida, outpatient family health centers in West Palm Beach and St. Lucie, an outpatient family health and ambulatory surgery center in Coral Springs and numerous physician offices located throughout Southeast Florida. In addition, the System operates a health and wellness center and a sports medicine clinic in 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 January 1, 2019, the Clinic through a subsidiary became the sole member of Martin Memorial Health Systems, Inc. (Martin) and Indian River Memorial Hospital, Inc. (Indian River) through non-cash business combination transactions. The business combinations were recorded under the acquisition method of accounting. The System recorded the fair value of the assets acquired of $1,116 million and the liabilities assumed of $526 million as of January 1, 2019. The fair value of net assets of $590 million was recognized in the consolidated statement of operations and changes in net assets for the three months ended March 31, 2019 as a member substitution contribution of $519 million included in other nonoperating gains and losses and contributions of net assets with donor restrictions of $71 million. The accounting for the business combinations represents estimated fair values of assets acquired and liabilities assumed based on preliminary information and is subject to change as the System completes the valuation analysis. The valuation is expected to be completed is by the end of 2019.

3. Business Combinations (continued)

The results of operations for Martin and Indian River are included in the consolidated statements of operations and changes in net assets beginning on January 1, 2019. For the three months ended March 31, 2019, Martin had total unrestricted revenues of $160.5 million, operating income of $3.9 million and an excess of revenues over expenses of $16.4 million. For the three months ended March 31, 2019, Indian River had total unrestricted revenues of $85.3 million, operating income of $2.5 million and an excess of revenues over expenses of $3.1 million. The operations of Martin and Indian River did not have a material impact on changes in net assets with donor restrictions.

4. Accounting Policies

Recent Accounting Pronouncements

Adopted

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 finance leases to be recognized on the lessee balance sheet. ASU 2016-02 also requires additional disclosures on the amount, timing and uncertainty of cash flows arising from leases. The System adopted ASU 2016-02 on January 1, 2019 using a modified retrospective approach. The impact of adoption on the consolidated financial statements resulted in an increase in other noncurrent assets to record right-of-use assets and an increase in other current and noncurrent liabilities to record lease obligations for operating leases of approximately $380 million representing the present value of remaining lease payments for operating leases. The adoption of ASU 2016-02 did not have a material impact on excess of revenues over expenses or net assets.

Not Yet Adopted

In June 2018, the FASB issued ASU No. 2018-08, *Not-for-Profit Entities, Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. This ASU intends to clarify and improve current accounting guidance to determine when a transaction should be accounted for as a contribution or as an exchange transaction and provides additional guidance about how to determine whether a contribution is conditional. The ASU is effective for the System for annual reporting periods beginning after June 15, 2018 for contributions received and after December 15, 2018 for contributions made, and interim periods beginning after December 31, 2019 with early adoption permitted. The System is currently assessing the impact that ASU 2018-08 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

4. Accounting Policies (continued)

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement, Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement*. This ASU intends to improve the effectiveness of disclosures in the notes to financial statements by modifying disclosure requirements for fair value measurements. The ASU is effective for the System for annual and interim reporting periods beginning after December 15, 2019 with early adoption permitted. The System is currently assessing the impact that ASU 2018-13 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

In August 2018, the FASB issued ASU No. 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General, Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans*. This ASU intends to improve the effectiveness of disclosures in the notes to financial statements by modifying disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. The ASU is effective for the System for annual reporting periods ending after December 15, 2021 with early adoption permitted. The System is currently assessing the impact that ASU 2018-14 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

In August 2018, the FASB issued ASU No. 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software, Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract*. This ASU aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The ASU is effective for the System for annual reporting periods beginning after December 15, 2020, and interim periods beginning after December 15, 2021 with early adoption permitted. The System is currently assessing the impact that ASU 2018-15 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 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 or actual charges. The System believes that this method provides a reasonable 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. 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. The portfolios consist of major payor classes for inpatient revenue and outpatient revenue. Based on historical collection trends and other analyses, 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 explicit price concessions 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. Explicit price concessions are based on contractual agreements, discount policies and historical experience. 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.

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 explicit price concessions, 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 three months of 2019 or 2018.

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 estimated settlements were not significant in the first three months of 2019 and 2018.

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, net of price concessions, for the three months ended March 31, 2019 and 2018, is as follows (in thousands):

	2019		2018	
Medicare	**$ 908,019**	**40%**	$ 704,336	37%
Medicaid	**180,819**	**8**	159,391	8
Managed care and commercial	**1,182,986**	**52**	1,039,019	55
Self-pay	**11,061**	**-**	7,028	-
Net patient service revenue	**$ 2,282,885**	**100%**	$ 1,909,774	100%

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.

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

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

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

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

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

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

7. Fair Value Measurements (continued)

The following tables present the financial instruments measured at fair value on a recurring basis as of March 31, 2019 and December 31, 2018, based on the valuation hierarchy (in thousands):

March 31, 2019	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	**$ 819,531**	**$ 275**	$ –	**$ 819,806**
Fixed income securities:				
U.S. treasuries	**1,104,374**	**–**	**–**	**1,104,374**
U.S. government agencies	**–**	**29,141**	**–**	**29,141**
U.S. corporate	**–**	**294,767**	**–**	**294,767**
U.S. government agencies asset-backed securities	**–**	**216,570**	**–**	**216,570**
Corporate asset-backed securities	**–**	**89,988**	**–**	**89,988**
Foreign	**–**	**105,632**	**–**	**105,632**
Fixed income mutual funds	**127,263**	**–**	**–**	**127,263**
Common and preferred stocks:				
U.S.	**533,166**	**–**	**–**	**533,166**
Foreign	**328,902**	**4,973**	**–**	**333,875**
Equity mutual funds	**225,353**	**–**	**–**	**225,353**
Total cash and investments	**3,138,589**	**741,346**	**–**	**3,879,935**
Perpetual and charitable trusts	**–**	**83,206**	**–**	**83,206**
Total assets at fair value	**$ 3,138,589**	**$ 824,552**	$ –	**$ 3,963,141**
Liabilities				
Interest rate swaps	$ –	**$ 114,436**	$ –	**$ 114,436**
Foreign currency forward contracts	**–**	**3,254**	**–**	**3,254**
Total liabilities at fair value	$ –	**$ 117,690**	$ –	**$ 117,690**

7. Fair Value Measurements (continued)

December 31, 2018	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 911,624	$ 253	$ –	$ 911,877
Fixed income securities:				
U.S. treasuries	1,385,156	–	–	1,385,156
U.S. government agencies	–	20,889	–	20,889
U.S. corporate	–	108,240	–	108,240
U.S. government agencies asset-backed securities	–	94,399	–	94,399
Corporate asset-backed securities	–	31,477	–	31,477
Foreign	–	54,132	–	54,132
Fixed income mutual funds	122,034	–	–	122,034
Common and preferred stocks:				
U.S.	425,269	–	–	425,269
Foreign	288,773	3,862	–	292,635
Equity mutual funds	97,932	–	–	97,932
Total cash and investments	3,230,788	313,252	–	3,544,040
Perpetual and charitable trusts	–	63,991	–	63,991
Total assets at fair value	$ 3,230,788	$ 377,243	$ –	$ 3,608,031
Liabilities				
Interest rate swaps	$ –	$ 101,444	$ –	$ 101,444
Foreign currency forward contracts	$ –	$ 9,419	$ –	$ 9,419
Total liabilities at fair value	$ –	$ 110,863	$ –	$ 110,863

7. Fair Value Measurements (continued)

Financial instruments at March 31, 2019 and December 31, 2018 are reflected in the consolidated balance sheets as follows (in thousands):

	March 31 2019	December 31 2018
Cash, cash equivalents, and investments measured at fair value	**$ 3,879,935**	$ 3,544,040
Commingled funds measured at net asset value	**2,672,611**	2,654,193
Alternative investments accounted for under the equity method	**2,830,991**	2,735,233
Total cash, cash equivalents, and investments	**$ 9,383,537**	$ 8,933,466
Perpetual and charitable trusts measured at fair value	**$ 83,206**	$ 63,991
Interests in foundations	**24,624**	23,615
Trusts and interests in foundations	**$ 107,830**	$ 87,606

Interest rate swaps and foreign currency forward contracts (*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 2.8% 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 health care entities' bonds. The System manages credit risk based on the net portfolio exposure with each counterparty.

The fair value of foreign currency forward contracts is based on the difference between the contracted exchange rate and current market foreign currency exchange rates adjusted for forward points, which are differences in prevailing deposit interest rates between each currency through the remaining term of the contract.

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 $623.4 million and $618.2 million at March 31, 2019 and December 31, 2018, respectively. These amounts exclude $29.9 million of notional amounts related to interest rate swaps assumed by the System from the Indian River member substitution that were terminated in the second quarter of 2019. During the term of these transactions, the System pays interest at a fixed rate and receives interest at a variable rate based on the London Interbank Offered Rate (LIBOR) or the Securities Industry and Financial Markets Association Index (SIFMA). The swap agreements are not designated as hedging instruments. Net interest paid or received under the swap agreements is included in derivative losses in the consolidated statements of operations and changes in net assets.

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 March 31 2019	Notional Amount at December 31 2018
Fixed	2021	3.21%	68%	of LIBOR	**$ 28,525**	$ 30,145
Fixed	2024	3.42%	68%	of LIBOR	**25,700**	26,500
Fixed	2024	3.45%	67%	of LIBOR	**7,290**	–
Fixed	2027	3.56%	68%	of LIBOR	**115,757**	120,113
Fixed	2028	5.12%	100%	of LIBOR	**35,430**	36,605
Fixed	2028	3.51%	68%	of LIBOR	**27,395**	28,285
Fixed	2030	5.07%	100%	of LIBOR	**57,250**	57,250
Fixed	2030	5.06%	100%	of LIBOR	**57,225**	57,225
Fixed	2031	3.04%	68%	of LIBOR	**44,000**	46,975
Fixed	2032	4.32%	79%	of LIBOR	**2,165**	2,189
Fixed	2032	4.33%	70%	of LIBOR	**4,330**	4,377
Fixed	2032	3.78%	70%	of LIBOR	**2,165**	2,189
Fixed	2032	3.58%	67%	of LIBOR	**10,590**	–
Fixed	2036	4.90%	100%	of LIBOR	**49,125**	49,125
Fixed	2036	4.90%	100%	of LIBOR	**76,125**	76,950
Fixed	2037	4.62%	100%	of SIFMA	**59,115**	59,115
Fixed	2039	4.62%	68%	of LIBOR	**21,170**	21,170
					$ 623,357	$ 618,213

The System is exposed to fluctuations in various foreign currencies against its functional currency, the U.S. dollar (USD). The System uses foreign currency forward contracts 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.

In November 2018, the System entered into three foreign currency forward contracts, expiring between May 2020 and April 2021, with a total outstanding notional amount of $336.2 million at March 31, 2019 and December 31, 2018. The foreign currency forward contracts are not designated as hedging instruments.

8. Derivative Instruments (continued)

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

	Derivatives Liability			
	March 31, 2019		December 31, 2018	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 114,436**	Other noncurrent liabilities	$ 101,444
Foreign currency contracts	Other noncurrent liabilities	**$ 3,254**	Other noncurrent liabilities	$ 9,419

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

	Location of (Loss) Gain Recognized	Quarter Ended March 31 2019	2018
Derivatives not designated as hedging instruments			
Interest rate swap agreements	Derivative (losses) gains	**$ (14,653)**	$ 15,416
Foreign currency contracts	Derivative gains	**$ 6,166**	$ –

The System has used various derivative contracts in connection with certain prior obligations and investments. Although minimum credit ratings are required for counterparties, this does not eliminate the risk that a counterparty may fail to honor its obligations. Derivative contracts are subject to periodic "mark-to-market" valuations. A derivative contract may, at any time, have a positive or negative value to the System. In the event that the negative value reaches certain thresholds established in the derivative contracts, the System is required to post collateral, which could adversely affect its liquidity. At March 31, 2019 and December 31, 2018, the System posted $69.6 million and $49.0 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 six defined benefit pension plans, including two plans related to Akron General, one plan related to Martin, and one plan related to Indian River. 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, Union Hospital, Martin, or Indian River. 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. All benefit accruals under the Akron General defined benefit plan ceased as of December 31, 2017. Martin has a tax-qualified defined benefit plan covering substantially all of its employees that were hired before October 1, 2005 who meet certain eligibility requirements. All benefit accruals under the Martin defined benefit plan ceased as of January 1, 2013. Indian River has a tax-qualified defined benefit plan covering substantially all of its employees that were hired before December 31, 2002 who meet certain eligibility requirements. All benefit accruals under the Indian River defined benefit plan ceased as of December 31, 2002. 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 six contributory, defined contribution plans covering System, Akron General and Union Hospital employees. The System also assumed two additional contributory, defined contribution plans from the Martin and Indian River member substitutions in January 2019. 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, Union Hospital, Martin or Indian River. 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 sponsors eight tax-qualified contributory, defined contribution plans, which collectively cover substantially all employees. The plans permit employees to make pretax employee deferrals and to become entitled to certain employer matching contributions that are based on employee contributions.

9. Pensions and Other Postretirement Benefits (continued)

The components of net periodic benefit cost for defined benefit pension plans are as follows (in thousands):

	Quarter Ended March 31	
	2019	**2018**
Amounts related to defined benefit pension plans:		
Service cost	**$ (855)**	$ (378)
Interest cost	**19,393**	16,178
Expected return on assets	**(21,410)**	(18,697)
Net amortization and deferral	**(478)**	(478)
Total defined benefit pension plans	**(3,350)**	(3,375)
Defined contribution plans	**71,712**	64,696
	$ 68,362	$ 61,321

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

As of March 31, 2019, the System has made contributions of $2.8 million to the defined benefit pension plans. The System expects to make additional contributions of $10.0 million to the defined benefit pension plans for the remainder of 2019.

10. Leases

The System has operating and finance leases for real estate and personal property and equipment. The System determines if an arrangement is a lease at the inception of a contract. Operating lease right-of-use assets are included in other noncurrent assets and operating lease liabilities are included in other current and noncurrent liabilities in the consolidated balance sheets. The System had right-of-use assets and lease liabilities for operating leases totaling approximately $359 million and $380 million, respectively, at March 31, 2019. Finance lease right-of-use assets are included in property, plant and equipment, and the related lease liabilities are included in current portion of long-term debt and long-term debt in the consolidated balance sheets. The System had right-of-use assets and lease liabilities for finance leases totaling approximately $113 million and $120 million, respectively, at March 31, 2019. Right-of-use assets obtained in exchange for new operating and finance leases were not significant for the three months ending March 31, 2019. Leases with an initial term of twelve months or less are not recorded in the balance sheet.

10. Leases (continued)

The System has lease agreements which require payments for lease and non-lease components and has elected to account for these as a single lease component. For leases that commenced before the effective date of ASU 2016-12, the System elected the permitted practical expedients to not reassess the following: (i) whether any expired or existing contracts contain leases; (ii) the lease classification for any expired or existing leases; and (iii) initial direct costs for any existing leases.

Right-of-use assets represent the System's right to use an underlying asset during the lease term and lease liabilities represent the System's obligation to make lease payments arising from the lease. Right-of-use assets and liabilities are recognized at the commencement date based on the net present value of fixed lease payments over the lease term. The System's lease term include options to extend or terminate the lease when it is reasonably certain that the option will be exercised. Right-of-use assets also include any advance lease payments as well as adjustments made to the lease in order to account for non-straight line cash payments through the life of the lease. As most of the System's operating leases do not provide an implicit rate, the System uses its incremental borrowing rate based on the information available at commencement date in determining the present value of lease payments. The System considers recent debt issuances as well as publicly available data for instruments with similar characteristics when calculating its incremental borrowing rates. Finance lease agreements generally include an interest rate that is used to determine the present value of future lease payments. Operating fixed lease expense and finance lease depreciation expense are recognized on a straight-line basis over the lease term.

Operating expenses for the leasing activity of the System as lessee for the three months ending March 31, 2019 are as follows (in thousands):

	Classification	Amount
Operating lease expense	Facilities expense	$ 21,549
Financing lease interest	Interest expense	1,389
Financing lease amortization	Depreciation and amortization	6,666
Total lease cost		$ 29,604

Supplemental cash flow information is as follows (in thousands):

	Three Months Ended March 31, 2019
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	$ 22,953
Operating cash flows from finance leases	1,389
Financing cash flows from finance leases	5,967
Total	$ 31,832

10. Leases (continued)

The aggregate future lease payments for operating and finance leases as of March 31, 2019 were as follows (in millions):

	Operating	Finance
2019 (excluding the three months ending March 31, 2019)	$ 35,902	$ 21,170
2020	48,789	24,452
2021	44,889	20,308
2022	41,147	15,453
2023	36,675	11,659
Thereafter	1,242,753	50,114
Total lease payments	1,450,155	143,066
Less: Interest	(1,070,063)	(23,342)
Present value of lease liabilities	$ 380,092	$ 119,724

Average lease terms and discount rates were as follows:

	March 31, 2019
Weighted-average remaining lease term (years):	
Operating leases	73.6
Finance leases	7.9
Weighted-average discount rate:	
Operating leases	3.2%
Finance leases	4.5%

11. Subsequent Events

The System evaluated events and transactions occurring subsequent to March 31, 2019 through May 30, 2019, 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 May 2019, pursuant to certain agreements between the System and the Martin County Health Facilities Authority, the Martin County Health Facilities Authority issued $247.0 million of fixed-rate Hospital Revenue Bonds (Series 2019A Bonds) for the benefit of the System. Proceeds from the sale of the Series 2019A Bonds were used to acquire the ownership interest in Martin Health System and to pay the cost of issuance. Contemporaneously with the issuance of the Series 2019A Bonds, certain outstanding debt previously incurred by Martin Health System was defeased. Also in May 2019, pursuant to certain agreements between the System and the State of Ohio (State) acting by and through the Ohio Higher Education Facility Commission, the State issued $250.3 million of fixed-rate Hospital Revenue Bonds (Series 2019B Bonds), $89.0 million of adjustable floating-rate Hospital Revenue Bonds (Series 2019C Bonds) and $380.2 million of variable-rate Hospital Revenue Bonds, comprised of separate issues of $119.3 million (Series 2019D Bonds), $130.4 million (Series 2019E Bonds) and $130.4 million (Series 2019F Bonds). Proceeds from the issuance of the Series 2019C Bonds and Series 2019D Bonds have been or will be used to acquire facilities currently leased by the System under operating lease agreements and to pay the cost of issuance. Proceeds from the issuance of the Series 2019B Bonds, Series 2019E Bonds and Series 2019F Bonds have been or will be used to finance certain capital expenditures of the System and to pay the cost of issuance.

Unaudited Consolidating Balance Sheets

($ in thousands)

	March 31, 2019				December 31, 2018			
	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	$ 137,001	$ 175,967	$ -	$ 312,968	$ 279,847	$ 164,916	$ -	$ 444,763
Patient receivables, net	1,144,378	214,644	(35,673)	1,323,349	1,008,777	150,582	(36,441)	1,122,918
Due from affiliates	21,469	60,585	(82,054)	-	5,053	20	(5,073)	-
Investments for current use	-	53,841	-	53,841	-	53,841	-	53,841
Other current assets	384,313	125,056	(4,413)	504,956	359,623	67,392	(550)	426,465
Total current assets	1,687,161	630,093	(122,140)	2,195,114	1,653,300	436,751	(42,064)	2,047,987
Investments:								
Long-term investments	7,379,273	613,842	-	7,993,115	6,959,237	574,431	-	7,533,668
Funds held by trustees	84,068	119	-	84,187	49,353	24	-	49,377
Assets held for self-insurance	-	119,586	-	119,586	-	106,966	-	106,966
Donor restricted assets	767,044	52,796	-	819,840	715,268	29,583	-	744,851
	8,230,385	786,343	-	9,016,728	7,723,858	711,004	-	8,434,862
Property, plant, and equipment, net	4,575,659	1,101,890	-	5,677,549	4,144,790	927,674	-	5,072,464
Other assets:								
Pledges receivable, net	151,217	9,840	-	161,057	150,876	1,572	-	152,448
Trusts and beneficial interests in foundations	67,883	39,947	-	107,830	67,279	20,327	-	87,606
Other noncurrent assets	820,351	211,306	(198,302)	833,355	546,032	63,367	(197,637)	411,762
	1,039,451	261,093	(198,302)	1,102,242	764,187	85,266	(197,637)	651,816
Total assets	$ 15,532,656	$ 2,779,419	$ (320,442)	$ 17,991,633	$ 14,286,135	$ 2,160,695	$ (239,701)	$ 16,207,129

	March 31, 2019				December 31, 2018			
	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	$ 379,708	$ 101,215	$ (116)	$ 480,807	$ 448,095	$ 79,693	$ (116)	$ 527,672
Compensation and amounts withheld from payroll	378,569	64,925	-	443,494	329,434	29,908	-	359,342
Short-term borrowings	-	-	-	-	0	0	-	-
Current portion of long-term debt	195,744	11,045	(72)	206,717	185,676	5,746	(72)	191,350
Variable rate debt classified as current	318,394	56,752	-	375,146	351,024	56,752	-	407,776
Due to affiliates	14,170	22,593	(36,763)	-	20	5,053	(5,073)	-
Other current liabilities	393,915	123,009	(38,501)	478,423	411,584	121,009	(39,140)	493,453
Total current liabilities	1,680,500	379,539	(75,452)	1,984,587	1,725,833	298,161	(44,401)	1,979,593
Long-term debt	3,259,860	765,238	(193,567)	3,831,531	3,028,825	723,115	(193,029)	3,558,911
Other liabilities:								
Professional and general insurance liability reserves	66,533	96,501	-	163,034	55,556	85,626	-	141,182
Accrued retirement benefits	455,065	55,628	-	510,693	420,436	45,091	-	465,527
Other noncurrent liabilities	737,020	249,186	(49,303)	936,903	505,891	36,289	(151)	542,029
	1,258,618	401,315	(49,303)	1,610,630	981,883	167,006	(151)	1,148,738
Total liabilities	6,198,978	1,546,092	(318,322)	7,426,748	5,736,541	1,188,282	(237,581)	6,687,242
Net assets:								
Without donor restrictions	8,259,829	1,132,592	(2,120)	9,390,301	7,547,813	919,775	(2,120)	8,465,468
With donor restrictions	1,073,849	100,735	-	1,174,584	1,001,781	52,638	-	1,054,419
Total net assets	9,333,678	1,233,327	(2,120)	10,564,885	8,549,594	972,413	(2,120)	9,519,887
Total liabilities and net assets	$ 15,532,656	$ 2,779,419	$ (320,442)	$ 17,991,633	$ 14,286,135	$ 2,160,695	$ (239,701)	$ 16,207,129

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

Unaudited Consolidating Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended March 31, 2019				Three Months Ended March 31, 2018			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 2,002,088	$ 354,984	$ (74,187)	$ 2,282,885	$ 1,763,693	$ 214,010	$ (67,929)	$ 1,909,774
Other	195,661	82,788	(38,995)	239,454	184,278	65,418	(37,019)	212,677
Total unrestricted revenues	2,197,749	437,772	(113,182)	2,522,339	1,947,971	279,428	(104,948)	2,122,451
Expenses								
Salaries, wages, and benefits	1,243,135	251,994	(83,972)	1,411,157	1,112,501	148,873	(78,154)	1,183,220
Supplies	208,322	40,972	(74)	249,220	181,873	21,488	(162)	203,199
Pharmaceuticals	274,357	27,542	-	301,899	234,030	20,195	-	254,225
Purchased services and other fees	139,171	32,827	(7,383)	164,615	109,475	23,671	(4,886)	128,260
Administrative services	29,391	25,261	(5,428)	49,224	29,757	15,493	(5,273)	39,977
Facilities	73,466	22,933	(630)	95,769	68,373	17,612	(755)	85,230
Insurance	20,757	20,147	(15,670)	25,234	17,281	18,286	(15,693)	19,874
	1,988,599	421,676	(113,157)	2,297,118	1,753,290	265,618	(104,923)	1,913,985
Operating income before interest, depreciation, and amortization expenses	209,150	16,096	(25)	225,221	194,681	13,810	(25)	208,466
Interest	33,135	6,616	-	39,751	29,371	3,630	-	33,001
Depreciation and amortization	128,674	20,619	(25)	149,268	111,259	15,821	(25)	127,055
Operating income (loss) before special charges	47,341	(11,139)	-	36,202	54,051	(5,641)	-	48,410
Special charges	-	-	-	-	-	834	-	834
Operating income (loss)	47,341	(11,139)	-	36,202	54,051	(6,475)	-	47,576
Nonoperating gains and losses								
Investment return	337,243	34,397	-	371,640	34,199	2,905	-	37,104
Derivative losses	(8,027)	(460)	-	(8,487)	15,940	(524)	-	15,416
Other, net	332,543	187,478	-	520,021	1,594	4,782	-	6,376
Net nonoperating gains and losses	661,759	221,415	-	883,174	51,733	7,163	-	58,896
Excess (deficiency) of revenues over expenses	709,100	210,276	-	919,376	105,784	688	-	106,472

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

Martin Memorial Medical Center, a subsidiary of Martin Health System, became a member of the Obligated Group in May 2019. The financial results of Martin Memorial Medical Center are reported in the Obligated Group beginning January 1, 2019, which is the date they joined the System.

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

($ in thousands)

Change in Net Assets

	Three Months Ended March 31, 2019				Three Months Ended March 31, 2018			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Changes in net assets without donor restrictions:								
Excess of revenues over expenses	$ 709,100	$ 210,276	$ -	$ 919,376	$ 105,784	$ 688	$ -	$ 106,472
Net assets released from restriction for capital purposes	3,177	470	-	3,647	424	173	-	597
Retirement benefits adjustment	1,380	(57)	-	1,323	(658)	(57)	-	(715)
Foreign currency translation	-	457	-	457	-	13,000	-	13,000
Other	(1,641)	1,671	-	30	(299)	349	-	50
Increase in net assets without donor restrictions	712,016	212,817	-	924,833	105,251	14,153	-	119,404
Changes in net assets with donor restrictions:								
Gifts and bequests	26,083	9,387	-	35,470	25,149	60	-	25,209
Net investment income	24,305	1,703	-	26,008	(265)	465	-	200
Net assets released from restrictions used for operations included in other unrestricted revenues	(8,473)	(615)	-	(9,088)	(12,724)	(727)	-	(13,451)
Net assets released from restriction for capital purposes	(3,177)	(470)	-	(3,647)	(424)	(173)	-	(597)
Change in interests in foundations	1,008	-	-	1,008	-	-	-	-
Change in value of perpetual trusts	(424)	(158)	-	(582)	483	147	-	630
Member substitution contribution	32,738	38,250	-	70,988	-	-	-	-
Other	8	-	-	8	(24)	13	-	(11)
Increase in net assets with donor restrictions	72,068	48,097	-	120,165	12,195	(215)	-	11,980
Increase in net assets	784,084	260,914	-	1,044,998	117,446	13,938	-	131,384
Net assets at beginning of year	8,549,594	972,413	(2,120)	9,519,887	8,352,342	993,231	(2,120)	9,343,453
Net assets at end of period	$ 9,333,678	$ 1,233,327	$ (2,120)	$ 10,564,885	$ 8,469,788	$ 1,007,169	$ (2,120)	$ 9,474,837

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

Martin Memorial Medical Center, a subsidiary of Martin Health System, became a member of the Obligated Group in May 2019. The financial results of Martin Memorial Medical Center are reported in the Obligated Group beginning January 1, 2019, which is the date they joined the System.

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31, 2019				Three Months Ended March 31, 2018			
	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	$ 784,084	$ 260,914	$ -	$ 1,044,998	$ 117,446	$ 13,938	$ -	$ 131,384
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	(1,380)	57	-	(1,323)	658	57	-	715
Net realized and unrealized gains on investments	(352,087)	(32,616)	-	(384,703)	(24,481)	(2,839)	-	(27,320)
Depreciation and amortization	128,674	20,619	(25)	149,268	111,259	16,618	(25)	127,852
Foreign currency translation gain	-	(457)	-	(457)	-	(13,000)	-	(13,000)
Restricted gifts, bequests, investment income, and other	(50,972)	(10,932)	-	(61,904)	(25,367)	(672)	-	(26,039)
Transfers to (from) affiliates	1,637	(1,637)	-	-	323	(323)	-	-
Accreted interest and amortization of bond premiums	(1,509)	51	-	(1,458)	(1,548)	3	-	(1,545)
Net loss (gain) in value of derivatives	5,060	-	-	5,060	(19,843)	-	-	(19,843)
Member substitution	(364,448)	(225,720)	-	(590,168)	-	-	-	-
Changes in operating assets and liabilities:								
Patient receivables	(75,332)	(16,867)	(768)	(92,967)	(53,322)	(1,211)	(2,345)	(56,878)
Other current assets	(29,505)	(96,325)	80,844	(44,986)	19,046	(57,197)	38,172	21
Other noncurrent assets	(204,261)	(152,070)	690	(355,641)	2,970	(2,425)	165	710
Accounts payable and other current liabilities	(52,771)	31,249	(31,051)	(52,573)	(46,041)	(16,926)	13,422	(49,545)
Other liabilities	214,909	197,930	(49,152)	363,687	(5,853)	38,103	(49,254)	(17,004)
Net cash provided by (used in) operating activities and net nonoperating gains and losses	2,099	(25,804)	538	(23,167)	75,247	(25,874)	135	49,508
Financing activities								
Proceeds from long-term borrowings	2,624	538	(538)	2,624	-	135	(135)	-
Principal payments on long-term debt	(99,748)	(2,157)	-	(101,905)	(65,938)	(1,060)	-	(66,998)
Change in pledges receivable, trusts and interests in foundations	4,770	(1,496)	-	3,274	(4,011)	25	-	(3,986)
Restricted gifts, bequests, investment income, and other	50,972	10,932	-	61,904	25,367	672	-	26,039
Net cash (used in) provided by financing activities	(41,382)	7,817	(538)	(34,103)	(44,582)	(228)	(135)	(44,945)
Investing activities								
Expenditures for property and equipment	(126,161)	(20,499)	-	(146,660)	(141,516)	(17,038)	-	(158,554)
Member substitution cash contributions	(1,260)	17,657	-	16,397	-	-	-	-
Net change in cash equivalents reported in long-term investments	(12,331)	21,336	-	9,005	43,955	30,841	-	74,796
Purchases of investments	(1,777,733)	(125,645)	-	(1,903,378)	(401,182)	(31,237)	-	(432,419)
Sales of investments	1,815,559	130,788	-	1,946,347	440,757	39,195	-	479,952
Transfers (to) from affiliates	(1,637)	1,637	-	-	(323)	323	-	-
Net cash (used in) provided by investing activities	(103,563)	25,274	-	(78,289)	(58,309)	22,084	-	(36,225)
Effect of exchange rate changes on cash	-	3,764		3,764	-	(403)		(403)
(Decrease) increase in cash and cash equivalents	(142,846)	11,051	-	(131,795)	(27,644)	(4,421)	-	(32,065)
Cash and cash equivalents at beginning of year	279,847	164,916	-	444,763	27,644	213,583	-	241,227
Cash and cash equivalents at end of period	$ 137,001	$ 175,967	$ -	$ 312,968	$ -	$ 209,162	$ -	$ 209,162

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

Martin Memorial Medical Center, a subsidiary of Martin Health System, became a member of the Obligated Group in May 2019. The financial results of Martin Memorial Medical Center are reported in the Obligated Group beginning January 1, 2019, which is the date they joined the System.

Utilization

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

	Year Ended December 31			YTD March 31	
	2016	2017	2018	2018	2019
Total Staffed Beds[(1)]	3,931	3,847	4,143	3,866	4,881
Percent Occupancy[(1)]	69.3%	70.6%	68.8%	73.2%	69.9%
Inpatient Admissions[(1)]					
Acute	167,447	173,880	174,653	42,503	54,945
Post-acute	12,424	11,526	10,635	2,624	2,846
Total	179,871	185,406	185,288	45,127	57,791
Patient Days[(1)]					
Acute	857,990	890,353	901,801	225,995	276,911
Post-acute	103,979	92,449	79,737	19,668	21,441
Total	961,969	982,802	981,538	245,663	298,352
Average Length of Stay					
Acute	5.13	5.10	5.18	5.33	5.01
Post-acute	8.39	8.03	7.52	7.67	7.70
Surgical Facility Cases					
Inpatient	60,671	62,375	62,655	15,687	17,851
Outpatient	151,300	149,103	157,697	36,587	44,311
Total	211,971	211,478	220,352	52,274	62,162
Emergency Department Visits	652,073	644,185	675,657	160,452	217,640
Outpatient Observations	58,384	59,868	62,934	15,102	22,286
Outpatient Evaluation and Management Visits	4,235,729	4,407,973	4,632,296	1,252,357	1,530,565
Acute Medicare Case Mix Index - Health System	1.92	1.90	1.96	1.97	1.99
Acute Medicare Case Mix Index - Cleveland Clinic	2.53	2.59	2.71	2.74	2.74
Total Acute Patient Case Mix Index - Health System	1.82	1.84	1.89	1.91	1.90
Total Acute Patient Case Mix Index - Cleveland Clinic	2.45	2.52	2.63	2.64	2.63

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

Utilization statistics for Union Hospital are included beginning April 1, 2018, which is the date Union Hospital joined the System.

Utilization statistics for Martin Health System and Indian River Hospital are included beginning January 1, 2019, which is the date both entities joined the System.

Utilization (continued)

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

	Year Ended December 31			YTD March 31	
	2016	2017	2018	2018	2019
Total Staffed Beds[(1)]	3,412	3,352	3,477	3,371	3,968
Percent Occupancy[(1)]	69.6%	71.8%	70.9%	73.9%	71.3%
Inpatient Admissions[(1)]					
Acute	144,038	150,300	149,047	36,890	51,898
Post-acute	9,471	9,500	8,452	2,116	1,860
Total	153,509	159,800	157,499	39,006	53,758
Patient Days[(1)]					
Acute	755,138	778,333	785,433	199,249	264,857
Post-acute	76,113	77,908	62,644	15,850	13,879
Total	831,251	856,241	848,077	215,099	278,736
Surgical Facility Cases					
Inpatient	54,072	56,041	56,144	14,198	16,724
Outpatient	135,918	133,740	138,161	32,983	39,923
Total	189,990	189,781	194,305	47,181	56,647
Emergency Department Visits	535,478	530,384	531,822	133,224	194,439
Outpatient Observations	50,671	52,485	53,112	13,349	20,182
Outpatient Evaluation and Management Visits	4,232,729	4,404,070	4,628,353	1,140,409	1,499,674
Acute Medicare Case Mix Index	1.97	1.95	2.01	2.01	2.04
Total Acute Patient Case Mix Index	1.87	1.89	1.95	1.96	1.95

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

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

Payor Mix

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

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD March 31	
	2016	2017	2018	2018	2019
Payor					
Managed Care and Commercial	39%	38%	37%	38%	34%
Medicare	44%	46%	47%	46%	50%
Medicaid	14%	14%	14%	14%	13%
Self-Pay & Other	3%	2%	2%	2%	3%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD March 31	
	2016	2017	2018	2018	2019
Payor					
Managed Care and Commercial	40%	39%	38%	38%	36%
Medicare	44%	46%	47%	47%	49%
Medicaid	13%	13%	13%	13%	12%
Self-Pay & Other	3%	2%	2%	2%	3%
Total	100%	100%	100%	100%	100%

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

Payor mix for Union Hospital are included beginning April 1, 2018, which is the date Union Hospital joined the System.

Payor mix for Martin Health System and Indian River Hospital are included beginning January 1, 2019, which is the date both entities joined the System.

Research Support

($ in thousands)

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

	Year Ended December 31			YTD March 31	
	2016	**2017**	**2018**	**2018**	**2019**
External Grants Earned					
Federal Sources	$108,253	$114,942	$117,786	$29,035	$30,470
Non-Federal Sources	87,883	92,564	105,093	28,060	23,337
Total	196,136	207,506	222,879	57,095	53,807
Internal Support	59,326	59,873	63,327	10,897	18,836
Total Sources of Support	$255,462	$267,379	$286,206	$67,992	$72,643

Key Ratios

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

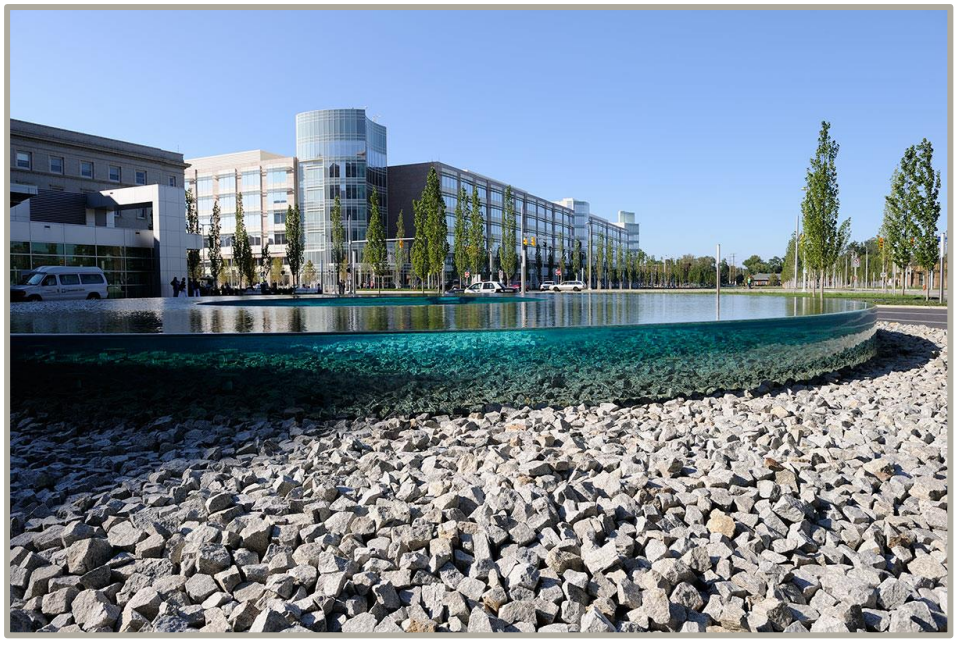
	Year Ended December 31			YTD March 31	
	2016	2017	2018	2018	2019
Liquidity ratios					
Days of cash on hand	349	383	355	382	330
Days of revenue in accounts receivable	51	49	49	50	52
Coverage ratios					
Cash to debt (%)	172.7	197.9	191.9	202.1	188.2
Maximum annual debt service coverage (x)	3.8	5.3	5.1	5.4	4.7
Interest expense coverage (x)	7.5	9.1	9.2	9.6	8.9
Debt to cash flow (x)	4.6	3.5	3.7	3.4	3.9
Leverage ratio					
Debt to capitalization (%)	36.4	32.5	32.9	31.9	32.0
Profitability ratios					
Operating margin (%)	3.0	3.9	3.0	2.2	1.4
Operating cash flow margin (%)	11.0	11.5	10.1	9.8	8.9
Excess margin (%)	6.2	12.5	1.2	4.9	27.0
Return on assets (%)	3.6	7.3	0.6	2.7	20.4

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

OVERVIEW

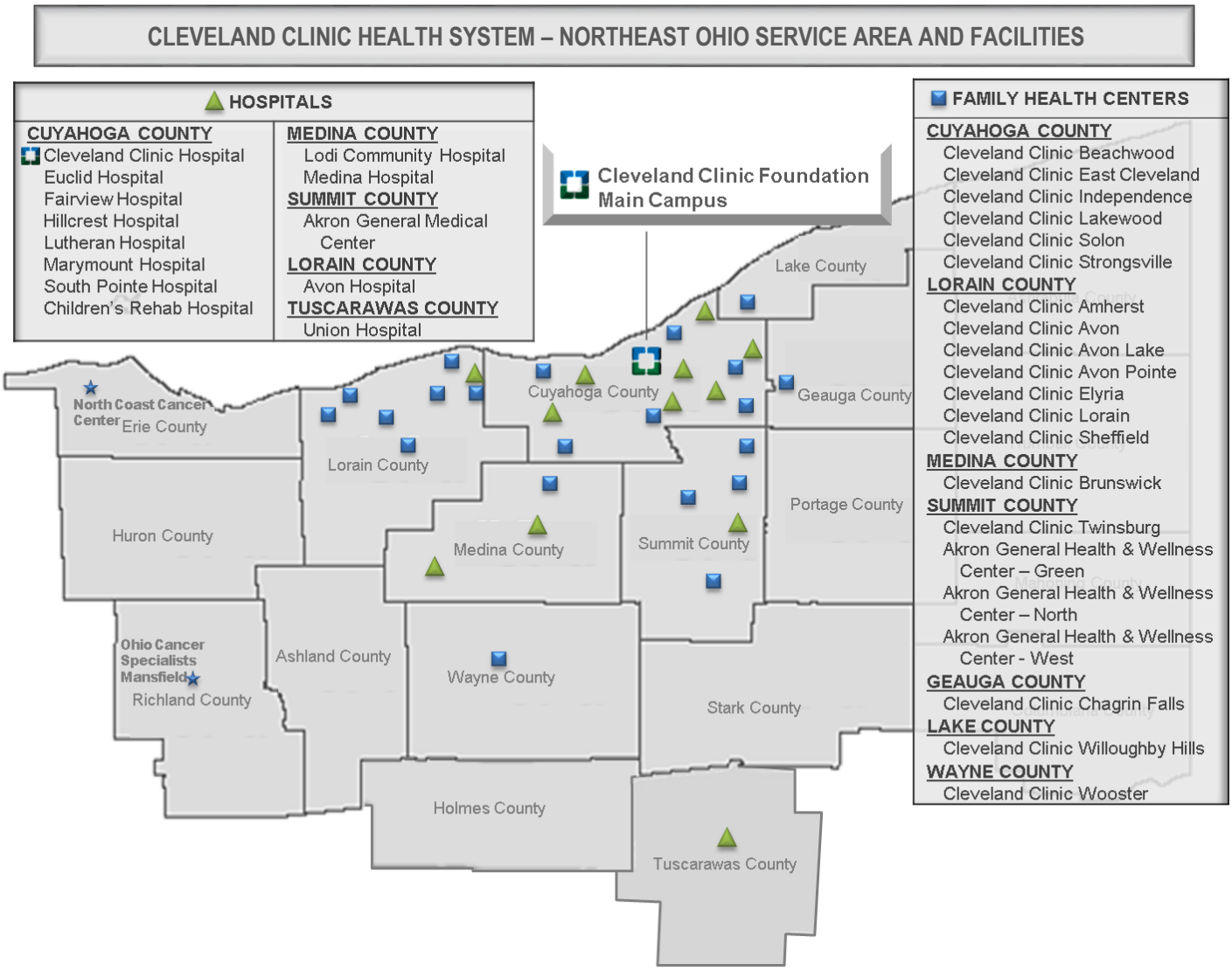
The Cleveland Clinic Health System (System) is a world-renowned provider of healthcare services that attracted patients from across the United States and from 132 other countries in 2018. The System operates 18 hospitals with approximately 4,900 staffed beds and is the leading provider of healthcare services in Northeast Ohio. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates 21 outpatient family health centers, 11 ambulatory surgery centers, as well as numerous physician offices, which are located throughout Northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In Florida, the System operates five hospitals and a clinic located throughout Southeast Florida, outpatient family health centers in West Palm Beach and St. Lucie, an outpatient family health and ambulatory surgery center in Coral Springs and numerous physician offices located throughout Southeast Florida. In addition, the System operates a health and wellness center and a sports medicine clinic in 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.

In January 2019, the Clinic through a subsidiary became the sole member of Martin Memorial Health Systems, Inc. (Martin Health System) and Indian River Memorial Hospital, Inc. (Indian River Hospital) through non-cash business combination transactions. Martin Health System and Indian River Hospital operate healthcare facilities in Southeast Florida. For a description of Martin Health System and Indian River Hospital, refer to "FLORIDA GROWTH."



Cleveland Clinic
Cleveland, Ohio

The location of the System's hospitals, its family health centers and its specialized cancer centers in the Northeast Ohio area are identified on the following map:



Cleveland Clinic

Every life deserves world class care.

The location of the System's hospitals and family health centers in the Southeast Florida area are identified on the following map:

CLEVELAND CLINIC HEALTH SYSTEM – SOUTHEAST FLORIDA FACILITIES

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 March 31, 2019:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,294
Avon Hospital	126
Euclid Hospital	165
Fairview Hospital	460
Hillcrest Hospital	440
Lutheran Hospital	194
Martin Hospital North	239
Martin Hospital South	97
Marymount Hospital	255
Medina Hospital	143
South Pointe Hospital	172
Tradition Hospital	177
Weston Hospital	206
	3,968
NON-OBLIGATED	
Akron General Medical Center	482
Children's Rehabilitation Hospital	25
Indian River Hospital	250
Lodi Hospital	20
Union Hospital	136
	913
HEALTH SYSTEM	4,881

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 24 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 14 specialties, including twelve in the top five nationwide, and is one of just 20 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:

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 2018-2019 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 counties. 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 the Cleveland metropolitan area and fifth in Ohio; Hillcrest Hospital ranked fourth in the Cleveland metropolitan area and sixth in Ohio; and South Pointe Hospital ranked fifth in the Cleveland metropolitan area and 13th 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 March 2019, the Clinic was named the second best hospital in the world by *Newsweek* in its list of "The 10 Best Hospitals in the World." The rankings were determined by a panel of doctors, medical professionals and administrators across four continents brought together by *Newsweek* and Statista Inc., a global market research and consumer data company. *Newsweek* supports this ranking by citing that the Clinic is among the largest medical providers in the world, performed the world's first total facial transplant, and was the first major medical center to organize with patient-center institutes to combine clinical services around a single disease or organ system.

In 2019, the Clinic was named one of the World's Most Ethical Companies by the Ethisphere Institute for the seventh consecutive year. Ethisphere Institute is a global leader in defining

and advancing the standards of ethical business practices. The award recognizes organizations that promote ethical business standards and practices internally, enable managers and employees to make good choices and shape future industry standards by introducing best practices. Companies were evaluated in five categories: ethics and compliance programs; corporate citizenship and responsibility; culture of ethics; governance; and leadership, innovation and reputation.

In March 2019, the Clinic was named the second most innovative hospital in the United States in a survey of more than 300 healthcare executives and staff conducted by Reaction Data. Hospitals were recognized based on survey participant opinions of organizations that were considered as being a model for innovation, quality care at a sustainable cost and thought leadership on topics related to healthcare transformation.

In April 2019, Avon Hospital was granted an Advanced Certification for Primary Stroke by the Joint Commission. With the addition of Avon Hospital, the System has eleven certified Primary Stroke Centers.

FINANCING DEVELOPMENTS

In May 2019, pursuant to certain agreements between the System and the Martin County Health Facilities Authority, the Martin County Health Facilities Authority issued $247.0 million of fixed-rate Hospital Revenue Bonds (Series 2019A Bonds) for the benefit of the System. Proceeds from the sale of the Series 2019A Bonds were used to acquire the ownership interest in Martin Health System and to pay the cost of issuance. Contemporaneously with the issuance of the Series 2019A Bonds, certain outstanding debt previously incurred by Martin Health System was defeased. Also in May 2019, pursuant to certain agreements between the System and the State of Ohio (State) acting by and through the Ohio Higher Education Facility Commission, the State issued $250.3 million of fixed-rate Hospital Revenue Bonds (Series 2019B Bonds), $89.0 million of adjustable floating-rate Hospital Revenue Bonds (Series 2019C Bonds) and $380.2 million of variable-rate Hospital Revenue Bonds, comprised of separate issues of $119.3 million (Series 2019D Bonds), $130.4 million (Series 2019E Bonds) and $130.4 million (Series 2019F Bonds). Proceeds from the issuance of the Series 2019C Bonds and Series 2019D Bonds have been or will be used to acquire facilities currently leased by the System under operating lease agreements and to pay the cost of issuance. Proceeds from the issuance of the Series 2019B Bonds, Series 2019E Bonds and Series 2019F Bonds have been or will be used to finance certain capital expenditures of the System and to pay the cost of issuance. The long-term rating assigned to the bonds issued in 2019 by Moody's Investor Service (Moody's) and Standard & Poor's (S&P) were Aa2 and AA, respectively.

In April 2019, Moody's affirmed its Aa2 rating on the obligated group's outstanding debt and maintained its 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 moderately high debt levels, execution risks of multiple strategies that require elevated capital spending, competition in the local market and Florida and

constrained revenue in Northeast Ohio due to weak demographic trends.

In April 2019, S&P affirmed its AA rating on the obligated group's 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 focus on outpatient services and the utilization of technology to provide healthcare services and a stable leadership team that has executed at a high level on its strategic plans. S&P also noted that the System has a robust research program and one of the largest medical residency programs in the nation. Challenges to the current rating include Northeast Ohio's unfavorable demographic trend, the System's robust capital spending program and a highly competitive service area in Northeast Ohio.

In August 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 proceeds of £300 million and £100 million in August 2018 and November 2018, respectively, and will receive additional proceeds of £265 million in August 2019. The 2018 Sterling Notes are guaranteed by the Cleveland Clinic obligated group and another UK subsidiary, mature at various dates from 2048 through 2068 and bear interest at an average fixed rate of 2.99%. The proceeds of the 2018 Sterling Notes repaid a $375.0 million term loan used to acquire a long-term leasehold interest in a building in London, England and have been or will be used 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 S&P.

Lou Ruvo Center for Brain Health
Las Vegas, Nevada

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 63 active Trustees, nine Professional Staff Trustees and 15 Emeritus Trustees. Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

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

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

The System maintains a governance model for the Ohio 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 Ohio regional hospital boards meet quarterly and, among other topics, provide local input on quality and patient safety and community health needs. Each Ohio regional hospital has a president, all of whom report to the President of Regional Hospitals and Family Health Centers.

Concurrently with Martin Health System and Indian River Hospital joining the System, the System established a separate Board of Directors to oversee the Florida hospitals. This Board of Directors has representatives from the Clinic Board of Directors and each of the Florida hospitals. Boards have also been maintained at Martin Health System and Indian River to provide local input on quality and patient safety and community health needs.

EXPANSION AND IMPROVEMENT PROJECTS

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

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

Health Education Campus - In 2013, the Clinic and Case Western Reserve University (CWRU) reached an agreement to build a health education campus on the Clinic's main campus to house the CWRU School of Medicine, which includes the Cleveland Clinic Lerner College of Medicine. The health education campus includes a four-story, 477,000-square-foot medical school facility that 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 also houses the CWRU Frances Payne Bolton School of Nursing and CWRU School of Dental Medicine. The medical school facility is designed to encourage interprofessional education. Construction of the medical school facility broke ground on October 1, 2015 and was completed in April 2019, with students expected to start classes in July 2019. CWRU and the Clinic shared in the construction costs of approximately $456 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. A separate three-story, 126,000-square-foot dental clinic is being constructed 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 it is expected to open in the summer of 2019.

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 conversion began in February 2017, and the facility is expected to 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 is currently in the midst of "The Power of Every One" philanthropic campaign. The campaign was publicly launched in 2014 with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the Clinic to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. As of March 31, 2019, the Clinic has received pledges, cash and other assets of approximately $1.6 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 in 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 88 companies, transacted more than 600 technology licenses, filed over 4,100 patent applications with over 1,500 issued patents, and acted on approximately 3,800 new inventions. In 2018, the Clinic executed 44 transactions to provide Clinic inventions to external organizations for development and commercialization in various fields, including orthopedics, 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.

Cleveland Clinic Innovations hosts an annual Medical Innovation Summit in downtown Cleveland 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 and its affiliated events held in October 2018 hosted approximately 2,000 attendees, who discussed the future of healthcare and the latest opportunities and challenges in the healthcare industry with various keynote addresses from authors and business leaders in healthcare. In addition to the keynotes, other highlights included a panel discussion featuring members of the care team that completed the face transplant at the Clinic in 2017 as well as the unveiling of the Top 10 Medical Innovations for 2019, 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 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.

The 2019 Medical Innovation Summit, *Caring for Every Life Through Innovation,* is scheduled for October 2019. The 2019 Summit will focus on artificial intelligence, new drug discovery, non-traditional participants and personalization in healthcare. The Clinic will also host a 2019 Value-Based Innovation Summit, which will run concurrently with the 2019 Medical Innovation Summit. Collectively, these summits will bring together clinical, financial and global benefit thought leaders from around the world for a discussion of best practices and solutions in value-based care and other forms of medical innovation. The Value-Based Innovation Summit theme for 2019 is *Best Practices in an Accountable World*.

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 March 2019, the Clinic announced that it would be expanding its affiliation agreement with Akron Children's Hospital that was initially established in 2014 to allow pediatric cardiovascular surgeons and adult congenital cardiologists to collaborate on patient cases, share best practices and combine outcome data. The expanded affiliation, now known as the Pediatric and Adult Congenital Heart Center, extends to all of pediatric cardiology and adult congenital cardiology, including clinical cardiology, imaging, interventional cardiology and cardiothoracic surgery. The new affiliation brings together a combined 30 pediatric cardiologists and surgeons from both organizations who specialize in children and adults with congenital heart disease.

AKRON GENERAL HEALTH SYSTEM

The Clinic became the sole member of Akron General Health System (Akron General) in November 2015. 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.

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. Discussions with the DOJ and related government authorities about the physician arrangements are ongoing, though a timeframe for completion of the inquiry by the government authorities that may arise under the Federal Anti-Kickback Statute, Stark Law, False Claims Act and/or other related laws and regulations cannot be estimated at this time. The outcome of the ongoing dialogue with the DOJ is not expected to be material to the System or 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 The Union Hospital Association (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 being integrated into and/or aligned with the System. The integration process is examining the operations and procedures at the various entities and looking for ways to improve the quality and delivery of care. The Clinic previously maintained an existing relationship with Union Hospital through the Telestroke Network, which connects patients to the Clinic's Cerebrovascular Center.

FLORIDA GROWTH

In January 2019, the Clinic through a subsidiary became the sole member of Martin Health System, located in Southeast Florida, approximately 100 miles north of Weston. Martin Health System is a regional not-for-profit, community-based healthcare provider consisting of three acute-care hospitals with approximately 513 staffed beds, a 150-member employed physician group and a network of outpatient services. As part of the agreement, the Clinic committed to invest at least $500 million into Martin Health System over five years to support strategic and capital needs, as well as other programs and services. The Clinic also will maintain certain clinical services at each of the Martin Health System hospitals for at least ten years.

In January 2019, the Clinic through a subsidiary became the sole member of Indian River Hospital, located in Southeast Florida approximately 130 miles north of Weston. Indian River Hospital is a not-for-profit medical center with approximately 250 staffed patient beds and is focused on providing healthcare to Indian River and surrounding counties in Florida. Under the terms of the transaction, the Clinic committed to invest at least $250 million in Indian River Hospital over the next decade and will maintain certain clinical services at Indian River Hospital for at least ten years. Indian River Hospital will continue to lease the hospital facilities and the land on which they stand under an amended and restated agreement with the Indian River County Hospital District for a term of up to 75 years.

Since the completion of the affiliations with Martin Health System and Indian River Hospital in January 2019, the services, programs and locations managed and operated by Martin Health System and Indian River Hospital are being integrated into and/or aligned with the Health System and their operations and procedures examined to look for opportunities to improve the quality and delivery of care.

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 is converting 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." A Chief Executive Officer has been appointed for Cleveland Clinic London, and senior leadership positions have been filled. The local leadership team is in the process of connecting with local physicians and third-party payors, recruiting additional staff and finalizing operational strategies in preparation of the 2021 opening.

In addition to the London project, the System operates a health and wellness center and a sports medicine clinic in Toronto, Canada, 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.

STRATEGY

The U.S. healthcare industry continues to undergo dramatic change with the intersection of economic pressure, insurance reform, technological breakthroughs and demographic shifts. At the center of this change is a shift in reimbursement models from fee for service to value-based and risk-based payments. This ongoing payment shift is occurring both in commercial and government payer segments, requiring healthcare delivery organizations to rethink fundamental capabilities for managing care. 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 take place, 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 advancing its mission and meeting its goals in an uncertain and vastly changing healthcare environment. Anchoring the strategy is the System's belief that modern not-for-profit healthcare

organizations must tend to four fundamental needs: care for the patients; care for the caregivers; care for the organization; and care for the community.

The strategy builds on the principles of the "Patients First" initiative started in 2013 by expanding and incorporating the four care priorities of patients, caregivers, community and organization. The strategic framework provides the System with the ability to prioritize activities and to focus on advancing the System's mission, vision, and values. In addition, the strategic framework addresses structural questions, including the formation of teams, governance of the System, allocation of resources and metrics to measure performance. In 2018, Cleveland Clinic launched several initiatives focused on important issues of quality, affordability, patient safety and caregiver wellbeing, including the following:

Care Model - Deliver innovative care across the continuum at the highest quality and value.

Care Resource Optimization - Develop a sustainable cost position.

Caregiver Experience - Make Cleveland Clinic the best place to work and grow in healthcare.

Community - Measurably improve well-being according to each community's unique needs.

Education & Research - Expand the foundation of education and research to enhance the mission of patient care.

Growth - Drive sustainable, transformative growth by securing core markets, expanding to new markets and serving more lives globally.

Patient Experience - Deliver an empathetic, seamless experience as a lifelong partner.

Payer - Enhance risk capabilities to drive performance across all payers and products.

Physician Growth & Alignment - Foster alignment and growth of the physician workforce.

Technology - Develop an industry leading digital and analytics platform.

In 2017, the System launched Cleveland Clinic Community Care, an institute 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 all report to the same unit. Primary care physicians are joined by advanced practice providers and medical assistants, who are supported by nurses, patient service representatives and care coordinators, working together to meet the needs of a specific group, or panel of patients. This single integrated care model brings together caregivers from primary and specialty care institutes and community providers in managing local populations and delivering community-based primary and chronic care. The model leverages data and an expanded care team to proactively address the health needs of populations.

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 continually monitor its use of resources in all clinical, operational and administrative areas. Since the inception of the program in 2014, management estimates that Care Resource Optimization initiatives and other localized efforts enabled more than $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 and the payment system to match the broader industry trend toward value-based contracting. The System continues to explore increased forms of risk-taking in payer contracts including pay-for-performance, bundled payments, global risk contracts and narrow network arrangements with payer partners. The System has implemented various risk contracting initiatives, including the co-branded insurance products with payer partners launched in 2018 that focus on specific product and consumer segments.

Leadership also is executing a focused growth strategy, domestically and internationally. A major emphasis of the domestic agenda is focused on developing and maintaining relationships with selected physician groups and hospitals throughout Northeast Ohio and partnering with community physicians in aligned, yet different, models. In Florida, the System has begun implementation of a multi-year growth plan that includes expansion of services at current facilities, new ambulatory facilities in surrounding communities and acquisition of healthcare facilities in Southeast Florida. The System will focus and prioritize initiatives to better prepare the Florida facilities for value-based care, while enhancing its position as the regional referral center for complex care. Internationally, the System is focusing on building strong relationships with physicians and medical centers around the world through outreach offices, research/education efforts, and an expanded global footprint.

Over the past several years, the System has pursued digitalization of care through virtual visit and telemedicine programs. These programs are being used to deploy distance health capabilities to more systematically connect physicians, patients and health systems to extend patient access, improve experience, increase efficiency and explore new care delivery models. Patient access initiatives are focused on providing lower cost, efficient care alternatives for lower acuity medical conditions to System patients. In 2018, the System averaged over 3,500 monthly virtual visits.

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 System's value to the market. The System is committed to a path not only to respond to the changes in the environment, but also to lead the field with novel approaches that preserve excellence in care while offering sustainable models for others to adopt.

COMMUNITY BENEFIT AND ECONOMIC IMPACT

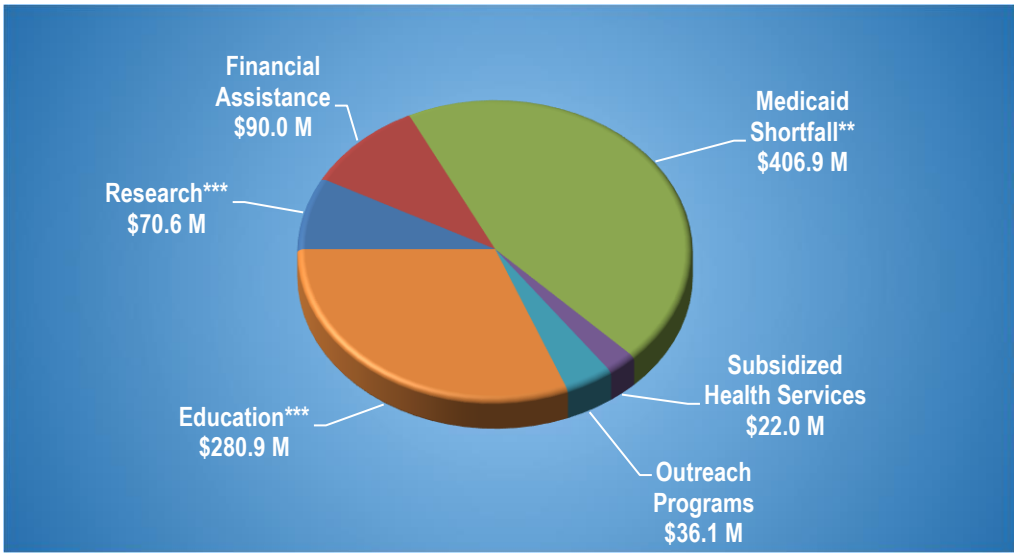
Community Benefit

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

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

In 2017, the System provided $906.5 million in benefits to the communities it serves. Community benefit information for 2018 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 (2017)
$906.5 Million



* Includes all System operations in Ohio, Florida and Nevada
** Includes net Hospital Care Assurance Program assessment of $8.3 million
*** Research and Education are reported net of externally sponsored funding of $159.7 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.

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.

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 tobacco 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 Orthopedic 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 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.

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).

Economic Impact

According to the System's most recent Economic and Fiscal Impact Report, the System is the largest employer in Northeast Ohio and the second largest employer in the State of Ohio. The current report was released in 2018 and was based on 2016 data, the most current data available at that time. In 2016 the System generated $17.8 billion of the total economic activity in Ohio and has directly and indirectly supported more than 119,000 jobs generating approximately $7.5 billion in wages and earnings. The System's economic activity was accountable for $2.25 billion in federal income taxes paid by employees and vendors and $987 million in total state and local taxes. System-supported households spent $5 billion on goods and services. The System has purchased almost $1.8 billion of goods and services from Ohio businesses. Between 2014 and 2016, the System's construction projects have invested almost $808 million in real property improvements, including renovating existing structures, building new facilities, and improving properties in Ohio. The System continues to contribute significant economic and fiscal value to the State of Ohio and support businesses and professional services across the state. In addition to Ohio, the System contributed $1.2 billion in total economic output in the State of Florida and $47 million of total economic output in the State of Nevada.

The System's Economic and Fiscal Impact Report is the result of an economic analysis completed by the Silverlode Consulting Corp. The report was completed in part using the IMPLAN® economic impact model, which is used by more than 1,000 universities and government agencies to estimate economic and fiscal impacts. Additional information regarding the System's economic impact is available on the Clinic's website (www.clevelandclinic.org/economicimpact).

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.

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 2019, the Clinic won the Top 25 Environmental Excellence Award for the fifth 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 three Circles of Excellence: Green Building, Greening the OR, and Energy. Other System entities and facilities were honored in 2019 with additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in healthcare sustainability.

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 16 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 Family Health and 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. The Office of Diversity and Inclusion (ODI), created in 2006, makes diversity, inclusion and cultural competence a critical part of the System's mission with a goal of creating a culture where caregivers integrate diversity and inclusion throughout the enterprise. ODI provides strategic direction that builds cultural competence, cultivates an inclusive organization, promotes safety, quality, and health equity, develops talent, and supports a diverse population of caregivers and patients. Its programs include cultural competence training, diversity councils, employee resource groups (ERG), language enrichment, consultation and 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 ranked in the top 25% of 500 corporations for diversity efforts on the Forbes list of Best Employers for Diversity for 2019. To determine the rankings, 50,000 Americans, working for businesses with at least 1,000 employees, were surveyed. Participants were asked to openly and anonymously share their opinions and rate their organizations on age, gender, ethnicity, disability, sexual orientation equality, general diversity and other criteria. This is the second year the System was recognized.

The SALUD ERG sponsored program, ACTiVHOS™, received financial support and approval to expand in 2019. ACTiVHOS™ stands for "Activity, Cognitive Therapy, and Incentives in Health Outreach for Students" and is the first and only bilingual/bi-cultural youth wellness program in Northeast Ohio. It was started by SALUD, the System's Hispanic/Latino ERG with support from ODI.

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 physicians, managers and other employees 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 its patients first. The Innovation Management and Conflict of Interest Program reviews situations in which a physician or other clinician 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 has been in place since 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 employees' 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 IRS on Form 990. The Form 990 for the Clinic and for 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. 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. The most recent comprehensive evaluation of top risks was concluded in the third quarter of 2016. ERM is an on-going program, with regular reporting to senior management, including the Audit Committee of the Board of Directors, the body with oversight responsibility for ERM.

INTERNAL CONTROL OVER FINANCIAL REPORTING

The System regularly evaluates its internal control environment over the System's financial reporting processes through an initiative based upon concepts established in the Sarbanes-Oxley Act of 2002. The goals of the initiative are to ensure the integrity and reliability of financial information, strengthen internal control in the reporting process, reduce the risk of fraud and improve efficiencies in the financial reporting process. The initiative reviews all aspects of the financial reporting process, identifies potential risks and ensures that they have been mitigated utilizing a management self-assessment process. As a result of this initiative, management of the System issued a report on the effectiveness of its internal control over financial reporting as part of the issuance of its consolidated financial results for 2018, which is the tenth year the management report was completed. As part of the internal control evaluation process for 2018, certifications were completed by 135 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 three months ended March 31, 2019 that have materially affected, or are likely to materially affect, the internal controls over financial reporting for the System.

INDUSTRY OUTLOOK

In December 2018, Moody's maintained its negative outlook for the U.S. not-for-profit healthcare and hospital sector, an outlook it has maintained since December 2017. Moody's expects operating cash flow to remain unchanged or decrease in the next year. The negative outlook also reflects Moody's expectation that hospital bad debt will continue to rise, predicting an 8%-9% growth in the next year as health plans place increased financial responsibility on patients. Moody's also predicts that an aging population will increase hospital reliance on Medicare, which may also constrain revenue growth. In August 2018, Moody's released medians for the U.S. not-for-profit healthcare and hospital sector that showed operating cash flow decreased to 8.1% for fiscal year 2017, which is the lowest level seen since the 2008/2009 recession.

In January 2019, 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, a long-term trend of improving business profiles primarily from mergers and acquisitions and a growing array of diversifying joint ventures. However, S&P does acknowledge that operating risks for some organizations exist, including a potential recession, continued Medicaid changes, increased traction from nontraditional competitors, and heightened cost and revenue pressure in part due to an aging population. S&P expects there to be continued uncertainty in the industry due to the various challenges and court rulings related to the Affordable Care Act. Rating performance in 2018 showed a generally even level of upgrades and downgrades, with approximately 81% of the rated portfolio with stable outlooks.

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 on a pro forma basis including Union Hospital, Martin Health System, and Indian River Hospital for all periods presented:

Utilization Statistics

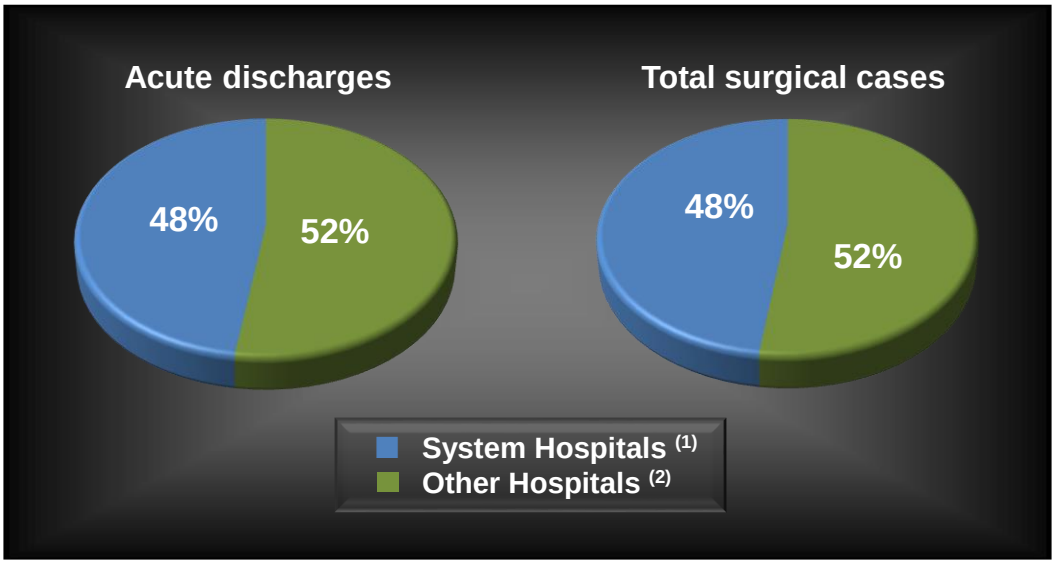
	For the quarter ended March 31			
	2019	2018	Variance	%
Inpatient admissions[(1)]				
Acute admissions	54,945	54,219	726	1.3%
Post-acute admissions	2,846	3,039	-193	-6.4%
	57,791	57,258	533	0.9%
Patient days[(1)]				
Acute patient days	276,911	277,788	-877	-0.3%
Post-acute patient days	21,441	22,064	-623	-2.8%
	298,352	299,852	-1,500	-0.5%
Surgical cases				
Inpatient	17,851	18,426	-575	-3.1%
Outpatient	44,311	41,469	2,842	6.9%
	62,162	59,895	2,267	3.8%
Emergency department visits	217,640	221,255	-3,615	-1.6%
Observations	22,286	20,481	1,805	8.8%
Clinic outpatient evaluation and management visits	1,530,565	1,455,906	74,659	5.1%

[(1)] Excludes newborns

Inpatient acute admissions for the System increased 1% in the first quarter of 2019 compared to the same period in 2018. In the first quarter of 2019, acute admissions for the System in the Northeast Ohio area remained flat compared to 2018, while the Florida facilities experienced a 4% increase in acute admissions over the same period. According to data from the Center for Health Affairs, acute discharges excluding newborns for hospitals in the Cleveland metropolitan area decreased 2% in the first quarter of 2019 compared to the same period in 2018.

Total surgical cases for the System increased 4% in the first quarter of 2019 compared to the same period in 2018. In the first quarter of 2019, total surgical cases for the System in the Northeast Ohio area increased 5%, while the Florida facilities remained flat over the same period. The surgical mix of total surgical cases for the System for the first quarter of 2019 was 29% inpatient and 71% outpatient, which represents an approximately 2% shift from inpatient to outpatient compared to the pro forma surgical mix for the same period in 2018.

The following charts summarize selected statistical information for Cleveland metropolitan hospitals for the three months ended March 31, 2019:



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 the Cleveland metropolitan area reported by the Center for Health Affairs that are not included in System hospitals.

Downtown Cleveland, Ohio

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 custodian. The Cleveland Clinic Investment Office (CCIO) is charged with the day-to-day management of the System's investments and their strategic direction. These portfolios include the System's general long-term investment portfolio, its defined benefit pension fund and the captive insurance fund. The System has established formal investment policies that support the System's investment objectives and provide an appropriate balance between return and risk.

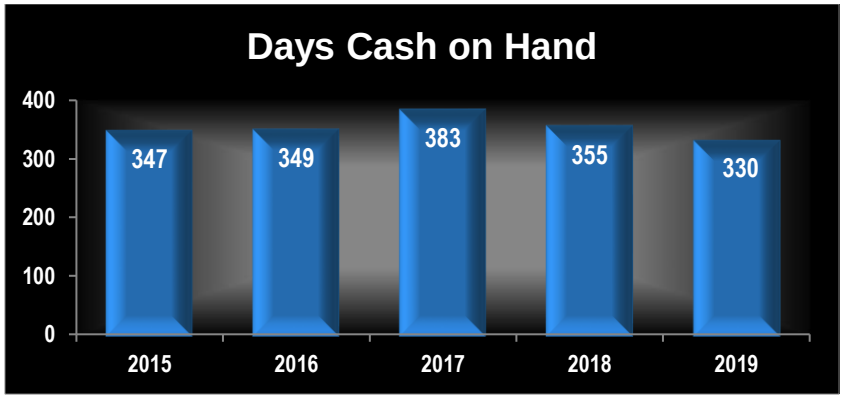
The following table sets forth the allocation of the System's cash and investments in its general long-term investment portfolio and captive insurance fund at March 31, 2019 and December 31, 2018:

Cash and Investments
(Dollars in thousands)

	March 31, 2019		December 31, 2018	
Cash and cash equivalents	$ 819,806	9%	$ 911,877	10%
Fixed income securities*	2,625,911	28%	2,509,157	28%
Marketable equity securities*	3,106,829	33%	2,777,199	31%
Alternative investments	2,830,991	30%	2,735,233	31%
Total cash and investments	$ 9,383,537	100%	$ 8,933,466	100%
Less restricted investments**	(1,077,454)		(955,035)	
Unrestricted cash and investments	$ 8,306,083		$ 7,978,431	
Days cash on hand	330		355	

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

The following chart summarizes days cash on hand for the System at December 31 for the last four years and at March 31, 2019:



At March 31, 2019, total cash and investments for the System (including restricted investments) were $9.4 billion, an increase of $450 million from $8.9 billion at December 31, 2018. Cash inflows consist of cash provided by operating activities and related investment income of $362 million, net proceeds from the issuance of long-term borrowings of $3 million, a net increase in restricted gifts and income of $65 million, foreign exchange gains on cash and cash equivalents of $4 million and cash and investments of $265 million received by the System from the Martin Health System and Indian River Hospital member substitution business combinations. Cash inflows were offset by net capital expenditures of $147 million and principal payments on debt of $102 million. Days cash on hand for the System in the first quarter of 2019 benefited from positive investment returns but was diluted as a result of the Martin Health System and Indian River Hospital member substitution business combinations.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $173.4 million at March 31, 2019, with an asset mix of 10% cash and short-term investments, 43% fixed-income securities, 25% equity investments and 22% alternative investments. The asset mix reflects the need for liquidity and the objective to maintain stable returns utilizing a lower tolerance for risk and volatility consistent with insurance regulatory requirements.

Also included in the System's cash and investments at March 31, 2019 are $84.2 million of funds held by trustees. Funds held by trustees include $69.9 million of posted collateral. Collateral is comprised of $0.3 million related to a futures and options program within the System's investment portfolio and $69.6 million 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. The System also has $12.4 million of funds held by trustee for a debt service reserve fund related to Martin Health System bonds and $14.3 million of funds held by trustee for other purposes. Investment objectives of funds held by the trustees are designed to preserve principal by investing in highly liquid cash or fixed-income investments. At March 31, 2019, the asset mix of funds held by trustees was 17% cash and short-term investments and 83% fixed-income securities.

The System invests in alternative investments to

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

Alternative investments at March 31, 2019 and December 31, 2018 consist of the following:

Alternative Investments
(Dollars in thousands)

	March 31, 2019		December 31, 2018	
Hedge funds	$ 1,471,643	52%	$ 1,357,553	50%
Private equity/venture capital	1,038,614	37%	1,007,692	37%
Real estate	320,734	11%	369,988	13%
Total alternative investments	$ 2,830,991	100%	$ 2,735,233	100%

Cole Eye Institute
Cleveland, Ohio

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 restricted investments is included in net assets with donor restrictions.

The System's long-term investment portfolio, which excludes assets held for self-insurance, reported investment gains of 4.8% for the first quarter of 2019, which is the same as the portfolio's benchmark and higher than break-even investment returns for the first quarter of 2018.

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

Investment Return
(Dollars in thousands)

	For the quarter ended March 31	
	2019	2018
Other unrestricted revenue:		
Interest income and dividends	$ 490	$ 627
Nonoperating gains and losses, net:		
Interest income and dividends	17,945	15,197
Net realized gains on sales of investments	49,470	67,638
Net change in unrealized gains (losses) on investments	278,420	(56,870)
Equity method income on alternative investments	32,464	17,604
Investment management fees	(6,659)	(6,465)
	371,640	37,104
Other changes in net assets:		
Investment income on restricted investments	26,008	200
Total investment return	$ 398,138	$ 37,931

Long-term Debt

At March 31, 2019, outstanding current and long-term debt for the System totaled $4.3 billion, comprised of $4.2 billion in bonds and notes and $121 million in finance leases. Bonds and notes are structured with approximately 79% fixed-rate debt and 21% variable-rate debt. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds and certain variable-rate operating lease payments. The total notional amount on the System's interest rate swap contracts at March 31, 2019 was $653 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.

As of March 31, 2019, approximately $428 million of the variable-rate debt is secured by irrevocable direct pay letters of credit or standby bond purchase agreements or is directly placed with a financial institution. Debt 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 Series 2019E Bonds and Series 2019F Bonds issued in May 2019 added a total of $260.8 million of variable-rate debt supported by standby bond purchase agreements to the System.

As of March 31, 2019, approximately $320 million of variable-rate debt is supported by the System's self-liquidity program. Debt supported by self-liquidity includes the Series 2014A CP Notes and certain variable-rate bonds that are remarketed in commercial paper mode. Debt supported by self-liquidity are classified as current liabilities. The Series 2019D Bonds issued in May 2019 added $119.3 million to the System's self-liquidity program.

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 March 31, 2019, the System had $38.3 million of outstanding Series 2014A CP Notes. The outstanding Series 2014A CP Notes were paid in the second quarter of 2019.

At March 31, 2019, the Clinic had a $300.0 million revolving credit facility with multiple financial institutions. The revolving credit facility was set to expire in 2019. The facility allowed the Clinic to enter into short-term loans that automatically renewed throughout the term of the facility. The revolving credit facility bore interest at a variable rate based on the LIBOR index plus an applicable spread. Amounts outstanding on the revolving credit facility as of March 31, 2019 and December 31, 2018 totaled $105.0 million. The Clinic paid the full amount and terminated the revolving credit facility in the second quarter of 2019.

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 proceeds of £300 million and £100 million in August 2018 and November 2018, respectively, and will receive additional proceeds of £265 million in August 2019. The outstanding 2018 Sterling Notes have been converted to U.S. dollars in the consolidated balance sheet using the exchange rate at March 31, 2019 and December 31, 2018. For a description of the 2018 Sterling Notes, refer to "FINANCING DEVELOPMENTS."

Outstanding long-term debt (including current portion) for the System as of March 31, 2019 and December 31, 2018 consist of the following:

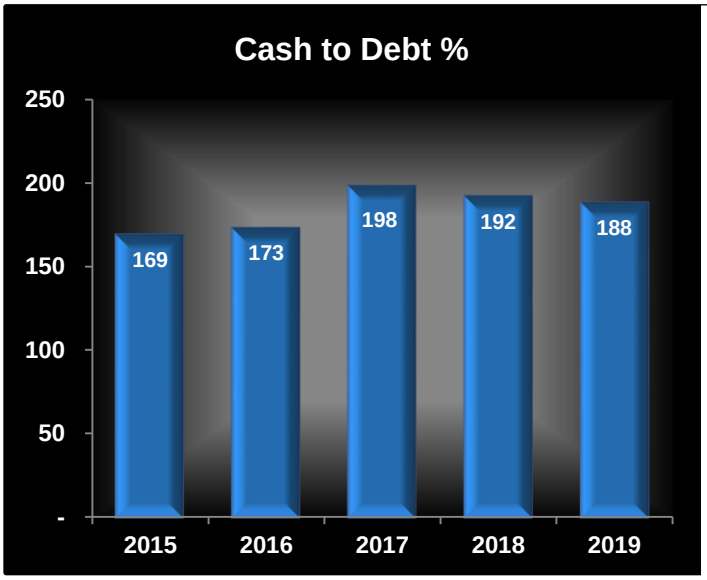
Hospital Revenue Bonds and Notes
(Dollars in thousands)

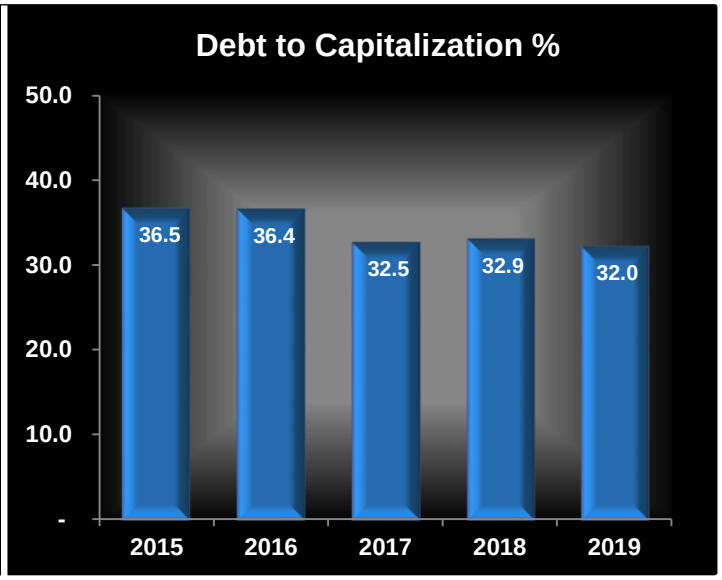
Series	Type	Final Maturity	March 31 2019	December 31 2018
2018 Sterling Notes[1]	Fixed	2068	$ 521,635	$ 509,476
2017A Revenue Bonds	Fixed	2043	812,205	818,775
2017B Revenue Bonds	Fixed	2043	167,580	169,255
2017C Revenue Bonds	Fixed	2032	8,555	8,945
2016 Private Placement	Fixed	2046	325,000	325,000
2016 Term Loan	Variable	2026	15,170	15,170
2014 Taxable Bonds	Fixed	2114	400,000	400,000
2014A CP Notes	CP	2044	38,325	70,955
2013A Revenue Bonds	Fixed	2042	62,650	62,650
2013B Revenue Bonds	Variable	2039	201,160	201,160
2013 Keep Memory Alive Bonds	Variable	2037	59,115	59,115
2012A Revenue Bonds	Fixed	2039	430,710	439,925
2011A Revenue Bonds	Fixed	2032	136,120	148,645
2011B Revenue Bonds	Fixed	2031	24,900	26,380
2011C Revenue Bonds	Fixed	2032	144,035	157,945
2009B Revenue Bonds	Fixed	2039	-	16,135
2008B Revenue Bonds	Variable	2043	327,575	327,575
2003C Revenue Bonds	Variable	2035	41,905	41,905
2010 Martin Bonds	Variable	2035	17,220	-
2012 Martin Bonds	Variable	2035	123,875	-
2012B Martin Bonds	Variable	2035	22,245	-
2013 Martin Bonds	Variable	2035	17,880	-
2015 Martin Bonds	Variable	2035	103,240	-
2018 Martin Taxable Loan	Variable	2035	15,475	-
Revolving Credit Facility	Variable	2019	105,000	105,000
Notes Payable	Varies	Varies	36,896	106
Finance leases	Varies	Varies	119,724	121,589
			$ 4,278,195	$ 4,025,706

[1]Converted to U.S. dollars using foreign exchange rates at the period end date

In May 2019, hospital revenue bonds totaling $966.5 million were issued for the benefit of the System. The proceeds of these bonds have been or will be used to refund all of the Series 2012 Martin, Series 2012B Martin and Series 2015 Martin Bonds, acquire facilities currently leased by the System under operating lease agreements, finance certain capital expenditures of the System and pay the cost of issuance. For a description of the bonds issued in 2019, refer to "FINANCING DEVELOPMENTS."

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 March 31, 2019:





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 April 2019, 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

Based on recent ratings summary reports obtained from Moody's and S&P, no healthcare organizations were rated in the prime category.

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended March 31, 2019 and 2018

The following narrative describes the consolidated results of operations for the System for the first quarters of 2019 and 2018. The consolidated results of operations for the first quarter of 2019 includes the financial operations of Martin Health System and Indian River Hospital, which became consolidated entities of the System in January 2019. For comparative purposes, certain financial activity in the narrative below is presented on a same facility basis, which excludes the financial operations of Martin Health System and Indian River Hospital for the first quarter of 2019.

Union Hospital joined the Health System in April 2018. For the first quarter of 2019, Union Hospital comprised approximately 1.2% of total consolidated operating revenues and 1.4% of total consolidated operating expenses. No adjustments have been made in the following

narrative to exclude Union Hospital operations except where indicated for comparative purposes.

Operating income for the System in the first quarter of 2019 was $36.2 million, resulting in an operating margin of 1.4%, as compared to operating income of $47.6 million and an operating margin of 2.2% in the first quarter of 2018. On a same facility basis (excluding Martin Health System and Indian River Hospital operating income of $3.9 million and $2.5 million, respectively), operating income for the Health System was $29.8 million, resulting in an operating margin of 1.3%. The lower operating income on a same facility basis resulted from an 8.3% increase in operating expenses that outpaced total unrestricted revenue growth of 7.3% in the same period. Nonoperating gains for the System were $883.2 million in the first quarter of 2019 compared to nonoperating gains of $58.9 million in the first quarter of 2018. The increase from the prior year was primarily due to member substitution contributions from Martin Health System and Indian River Hospital as well as favorable changes in the financial markets. Overall, the System reported an excess of revenues over expenses of $919.4 million in the first quarter of 2019 compared to an excess of revenues over expenses of $106.5 million in the first quarter of 2018.

The System's net patient service revenue increased $373.1 million (19.5%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, net patient service revenue increased $135.0 million (7.1%). Patient volumes on a same facility basis and excluding Union Hospital in the first quarter of 2019 were higher than the first quarter of 2018. The System experienced a 1.9% increase in same facility inpatient acute admissions, a 4.4% increase in same facility total surgical cases and a 4.5% increase in outpatient evaluation and management visits. Net patient revenue has also benefited from rate increases on the System's managed care contracts that became effective in 2019. Offsetting the patient volume and rate increases is a shift in the gross revenue payor mix that has negatively impacted the revenue realization of the System. The System has experienced an increase in Medicare revenue primarily as a result of demographic trends in the service area and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 0.5% in the first quarter of 2019 compared to the same period in 2018. The System has experienced a corresponding decrease in managed care and commercial gross revenues as a percentage of total gross patient revenues. 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 increased $26.8 million (12.6%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, other unrestricted revenues increased $19.1 million (9.0%). The increase in other unrestricted revenues was primarily due to a $10.8 million increase in outpatient pharmacy revenue.

Total operating expenses increased $411.3 million (19.8%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, total operating expenses increased $171.9 million (8.3%). Notable increases in expenses were primarily driven by higher patient volumes and were experienced in salaries, wages and benefits, supplies expenses and pharmaceutical costs. The System has implemented Care Resource Optimization initiatives to address the growth in expenses caused by inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals. Care

Resource Optimization 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 $227.9 million (19.3%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, salaries, wages and benefits increased $93.4 million (7.9%). Same facility salaries, excluding benefits, increased $85.2 million (8.5%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2018 and a 3.4% increase in average full-time equivalent employees in the first quarter of 2019 compared to the same period in 2018. Benefit costs increased $8.2 million (4.6%) during the same period. The System experienced a $5.8 million increase in FICA expenses and a $1.7 million increase in defined contribution expenses primarily due to the increase in salaries and full-time equivalent employees.

Supplies expense increased $46.0 million (22.6%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, supplies expense increased $13.0 million (6.4%). The increase in same facility supplies was comprised of a $7.4 million increase in implantables and other medical supplies primarily due to increased patient volumes and a $5.6 million increase in non-medical supplies primarily due to increased minor equipment purchases and dietary expenses.

Pharmaceutical costs increased $47.7 million (18.8%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, pharmaceutical costs increased $33.8 million (13.3%). The increase in same facility pharmaceutical costs 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 $8.1 million in the first quarter of 2019 compared to the same period in 2018. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $36.4 million (28.3%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, purchased services and other fees increased $17.0 million (13.2%). The increase in same facility purchased services and other fees was primarily related to a $4.2 million increase in software and hardware technology costs primarily related to maintenance agreements, current period software subscriptions and repair services, a $2.6 million increase in state franchise fee expenses and other various costs associated with certain System projects and initiatives.

Administrative services increased $9.2 million (23.1%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, administrative services increased $4.9 million (12.4%). The increase in same facility administrative services was primarily due to a $3.9 million increase is consulting and special project fees for various System strategic initiatives and a $0.7 million increase in expenses related to research projects.

Facilities expense increased $10.5 million (12.4%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, facilities expense increased $1.0 million (1.2%). The increase in same facility expenses

was primarily due to a $1.8 million increase in rent expenses.

Insurance expense increased $5.4 million (27.0%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, insurance expense in the first quarter of 2019 approximated the first quarter of 2018.

Interest expense increased $6.8 million (20.5%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, interest expense increased $2.9 million (8.9%). The increase in same facility interest expense is primarily due to the issuance of the 2018 Sterling Notes and an increase in interest rates on the System's variable rate bonds.

Depreciation and amortization expenses increased $22.2 million (17.5%) in the first quarter of 2019 compared to the same period in 2018. On a same facility basis, depreciation expense increased $6.7 million (5.2%). Changes in depreciation include property, plant and equipment that was fully depreciated in 2018, offset by depreciation for property, plant and equipment that was acquired and placed into service after the first quarter of 2018.

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 $883.2 million in the first quarter of 2019 compared to a net gain of $58.9 million in the first quarter of 2018, resulting in a favorable variance of $824.3 million. Investment returns were favorable by $334.5 million in the first quarter of 2019 compared to the same period in 2018. The System's long-term investment portfolio reported investment gains of 4.8% for the first quarter of 2019, which is higher than break-even returns experienced in the first quarter of 2018. Derivative gains and losses were unfavorable by $23.9 million in the first quarter of 2019 compared to the same period in 2018. Derivative gains and losses result from changes in the interest rate benchmark associated with the System's foreign exchange forward currency contracts and interest rate swap agreements, including net interest paid or received under the swap agreements. Other nonoperating gains and losses were favorable by $513.6 million in the first quarter of 2019 compared to the same period in 2018 primarily due to a $519.2 million member substitution contribution related to the acquisitions of Martin Health System and Indian River Hospital offset by a $3.8 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 – MARCH 31, 2019 COMPARED TO DECEMBER 31, 2018

The following narrative describes the consolidated balance sheets for the System as of March 31, 2019 and 2018. The consolidated balance sheets at March 31, 2019 includes Martin Health System and Indian River Hospital, which became consolidated entities of the System in January 2019. For comparative purposes, certain financial activity in the narrative below is also presented on a same facility basis, which excludes balance sheet information of Martin Health System and Indian River Hospital as of March 31, 2019.

Cash and cash equivalents decreased $131.8 million (29.6%) from December 31, 2018 to March 31, 2019. On a same facility basis, cash and cash equivalents decreased $159.1 million (35.8%). The decrease in same facility cash and cash equivalents is primarily due to $126.8 million of regularly scheduled debt service

payments in January 2019.The majority of the System's cash and cash equivalents are held in operating bank accounts for general expenditures.

Patient accounts receivable increased $200.4 million (17.8%) from December 31, 2018 to March 31, 2019. On a same facility basis, patient receivables increased $79.2 million (7.1%).The increase in same facility patient receivables is partially due to an increase in net patient service revenue resulting from increased levels of patient activity and rate increases on the System's managed care contracts that became effective in January 2019. The System has also experienced an increase in patient responsibility accounts receivable. Patient responsibility accounts represent the portion of services that is not paid by a patient's insurance company, typically in the form of co-pays and deductibles. Patient responsibility accounts receivable tend to be seasonally higher in the first quarter as many insurance plans have annual deductible requirements. These balances are generally more difficult to collect than traditional insurance payors. The System has various initiatives to enhance cash collection efforts and create efficiencies in the revenue cycle process, including the implementation of Enterprise Administrative Patient Management (EAPM), a project that consolidated billing, collections and other revenue cycle support services into one technology platform. EAPM was implemented at the Clinic in 2016 and at the System's community hospitals excluding Union Hospital at various phases throughout 2017 and 2018. Days revenue outstanding for the System increased from 49 days at December 31, 2018 to 52 days at March 31, 2019.

Other current assets increased $78.5 million (18.4%) from December 31, 2018 to March 31, 2019. On a same facility basis, other current assets increased $42.6 million (10.0%). The increase in same facility other current assets was primarily due to a $31.1 million increase in international management fee receivables and a $21.7 million increase in prepaid expenses driven by annual maintenance and information technology contracts. These increases were offset by an $8.0 million reduction in receivables related to the timing of receipts for various Medicare and Medicaid programs.

Unrestricted long-term investments increased $459.4 million (6.1%) from December 31, 2018 to March 31, 2019. On a same facility basis, unrestricted long-term investments increased $250.3 million (3.3%). The increase in same facility long-term investments was primarily due to $357.5 million of unrestricted investment income experienced in the System's investment portfolio, which experienced gains of 4.8% in the first three months of 2019. Offsetting this increase was a $32.6 million transfer to cash and cash equivalents to fund debt service and a $20.6 million transfer to funds held by trustee to post additional collateral related to the System's interest rate swap derivative contracts.

Funds held by trustees increased $34.8 million (70.5%) from December 31, 2018 to March 31, 2019. On a same facility basis, funds held by trustee increased $20.9 million (42.2%). The increase in same facility funds held by trustees is primarily due to a $20.6 million increase in collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance increased $12.6 million (11.8%) from December 31, 2018 to March 31, 2019. On a same facility basis, assets held for self-insurance increased $6.7 million (6.3%). The increase in same facility self-insurance assets is primarily due to positive investment returns in the System's captive insurance investment portfolio.

Donor restricted assets increased $75.0 million (10.1%) from December 31, 2018 to March 31,

2019. On a same facility basis, donor restricted investments increased $52.8 million (7.1%). The increase in same facility donor restricted assets was primarily from investment income on restricted investments and the receipt of donor restricted gifts in excess of expenditures from restricted funds.

Net property, plant and equipment increased $605.1 million (11.9%) from December 31, 2018 to March 31, 2019. On a same facility basis, property, plant and equipment decreased $6.3 million (0.1%). The System had same facility net expenditures for property, plant and equipment of $132.1 million, offset by depreciation expense of $133.6 million The System also had $8.9 million of foreign currency translation gains. Capital expenditures in 2019 include amounts paid on retainage liabilities recorded at December 31, 2018 and exclude assets acquired through finance leases and other financing arrangements. Retainage liabilities decreased $17.3 million, and new capital leases totaled $3.7 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 a few of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets decreased $450.4 million (69.1%) from December 31, 2018 to March 31, 2019. On a same facility basis, other noncurrent assets increased $325.5 million (49.9%). The increase in same facility noncurrent assets was primarily due to the adoption of accounting standard update 2016-02 *Leases*, which resulted in a $328.9 million right-of-use asset representing the present value of remaining lease payments for operating leases.

Accounts payable decreased $46.9 million (8.9%) from December 31, 2018 to March 31, 2019. On a same facility basis, accounts payable decreased $76.4 million (14.5%). The decrease in same facility accounts payable was primarily attributable to the timing of payment processing for trade payables and a $17.3 million decrease in retainage liabilities on current construction projects.

Compensation and amounts withheld from payroll increased $84.2 million (23.4%) from December 31, 2018 to March 31, 2019. On a same facility basis, compensation and amounts withheld from payroll increased $47.8 million (13.3%).The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $15.4 million (8.0%) from December 31, 2018 to March 31, 2019. On a same facility basis, Current portion of long-term debt increased $1.9 million (1.0%). Changes in the same facility current portion of long-term debt include the reclassification of regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments made in 2019.

Variable rate debt classified as current decreased $32.6 million (8.0%) from December 31, 2018 to March 31, 2019. On a same facility basis, variable rate debt classified as current decreased $32.6 million (8.0%). 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

a principal payment on the Series 2014A CP Notes, which are part of the System's self-liquidity program.

Other current liabilities decreased $15.0 million (3.0%) from December 31, 2018 to March 31, 2019. On a same facility basis, other current liabilities decreased $38.5 million (7.8%). The decrease in same facility other current liabilities is primarily due to a $30.6 million decrease in accrued interest payable related to debt that pays interest semi-annually in January and July of each year and a $20.9 million decrease in state franchise fee liabilities primarily related to the timing of payments to the State of Ohio. These decreases were offset by a $5.6 million increase in accrued employee health care benefit liabilities.

Long-term debt increased $272.6 million (7.7%) from December 31, 2018 to March 31, 2019. On a same facility basis, long-term debt decreased $55.5 million (1.6%). The decrease in same facility long-term debt is primarily due to the reclassification of regularly scheduled principal payments from long-term to current for debt payments due within one year.

Professional and general insurance liability reserves increased $21.9 million (15.5%) from December 31, 2018 to March 31, 2019. On a same facility basis, professional and general insurance liability reserves increased $1.1 million (0.8%). The increase in same facility insurance liability reserves is due to expenses recorded for the accrual of current year claim estimates in excess of claim liability payments.

Accrued retirement benefits increased $45.2 million (9.7%) from December 31, 2018 to March 31, 2019. On a same facility basis, accrued retirement benefits decreased $5.8 million (1.2%). The decrease in same facility accrued retirement benefits is comprised of a $4.9 million decrease in the System's defined benefit pension plan liabilities and a $0.9 million decrease in other postretirement benefit liabilities. The decrease in defined benefit pension plan liabilities was primarily due to net periodic benefit, which is resulting from the expected return on plan assets in excess of interest cost incurred on plan obligations.

Other noncurrent liabilities increased $394.9 million (72.9%) from December 31, 2018 to March 31, 2019. On a same facility basis, other noncurrent liabilities increased $340.8 million (62.9%). The increase in same facility other noncurrent liabilities is primarily due to the adoption of accounting standard update 2016-02 *Leases*, which resulted in a $349.9 million lease obligation representing the present value of remaining lease payments for operating leases.

Total net assets increased $1,045 million (11.0%) from December 31, 2018 to March 31, 2019. Net assets without donor restrictions increased $924.8 million (10.9%) primarily due to an excess of revenues over expenses of $919.4 million and net assets released from restriction for capital purposes of $3.6 million. Net assets with donor restrictions increased $120.2 million (11.4%), primarily due to a $71.0 million member substitution contribution, $35.5 million of donor restricted gifts and $26.0 million of restricted investment income. These increases were offset by $12.7 million in net assets released from restriction.

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 integrate the hospitals in Florida into a regional health system;
- 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;
- The ability of the Clinic to develop the London Hospital and establish relationships with payors in that market;
- 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.