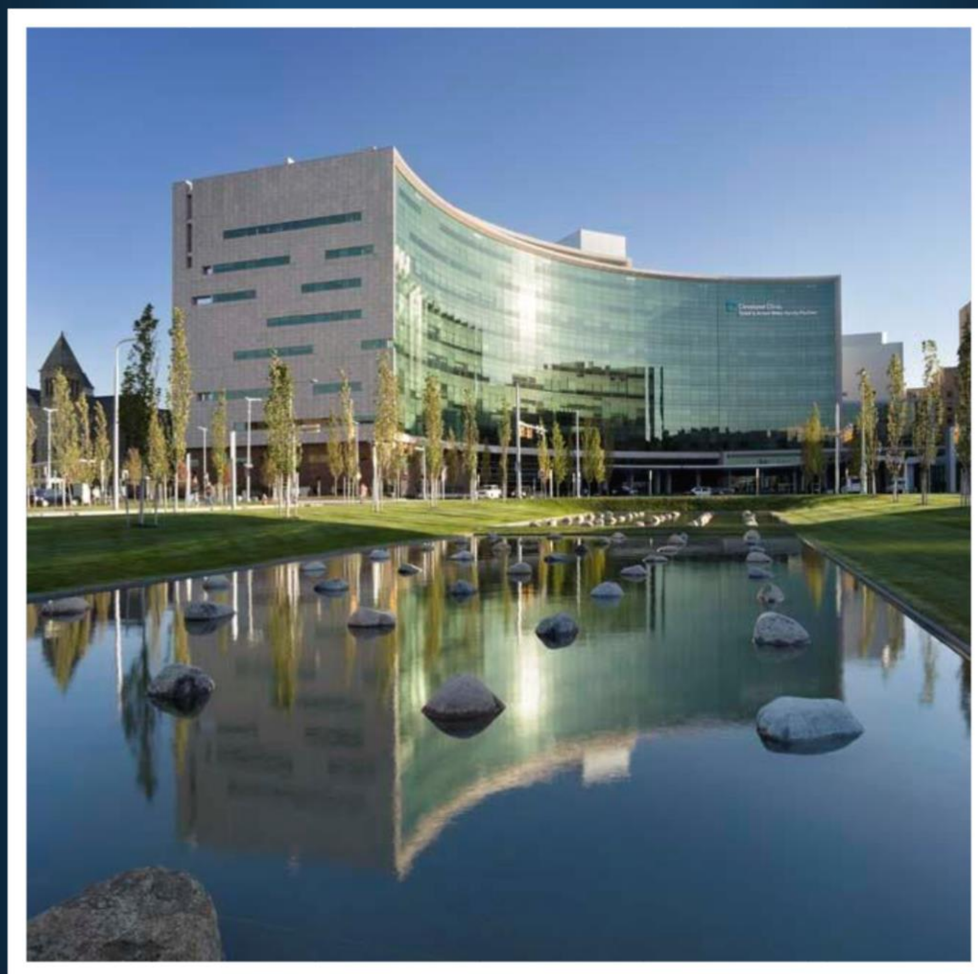
Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended June 30, 2016

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



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Unaudited Consolidated Balance Sheets

($ in thousands)

	June 30 2016	December 31 2015
Assets		
Current assets:		
Cash and cash equivalents	$ 278,959	$ 249,580
Patient receivables, net	1,056,457	950,304
Investments for current use	52,223	53,852
Other current assets	366,420	408,139
Total current assets	1,754,059	1,661,875
Investments:		
Long-term investments	6,089,486	6,184,378
Funds held by trustees	176,717	125,723
Assets held for self-insurance	113,027	93,662
Donor restricted assets	583,417	565,161
	6,962,647	6,968,924
Property, plant, and equipment, net	4,413,909	4,388,667
Other assets:		
Pledges receivable, net	140,811	141,468
Trusts and interests in foundations	84,369	86,741
Other noncurrent assets	377,535	353,748
	602,715	581,957
Total assets	$ 13,733,330	$ 13,601,423

Unaudited Consolidated Balance Sheets (continued)
($ in thousands)

	June 30 2016	December 31 2015
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 374,369	$ 412,559
Compensation and amounts withheld from payroll	357,474	295,668
Short-term borrowings	60,000	0
Current portion of long-term debt	175,237	95,694
Variable rate debt classified as current	459,940	520,960
Other current liabilities	441,998	467,042
Total current liabilities	1,869,018	1,791,923
Long-term debt:		
Hospital revenue bonds	2,585,102	2,725,760
Notes payable and capital leases	464,057	466,020
	3,049,159	3,191,780
Other liabilities:		
Professional and general insurance liability reserves	156,455	139,617
Accrued retirement benefits	490,721	490,753
Other noncurrent liabilities	537,370	478,352
	1,184,546	1,108,722
Total liabilities	6,102,723	6,092,425
Net assets:		
Unrestricted	6,738,530	6,627,406
Temporarily restricted	593,552	586,276
Permanently restricted	298,525	295,316
Total net assets	7,630,607	7,508,998
Total liabilities and net assets	$ 13,733,330	$ 13,601,423

See notes to unaudited consolidated financial statements.

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

Operations

	Three Months Ended June 30	
	2016	2015
Unrestricted revenues		
Net patient service revenue	$1,853,404	$1,616,745
Provision for uncollectible accounts	(76,089)	(61,535)
Net patient service revenue less provision for uncollectible accounts	1,777,315	1,555,210
Other	206,555	171,889
Total unrestricted revenues	1,983,870	1,727,099
Expenses		
Salaries, wages, and benefits	1,109,369	923,156
Supplies	189,971	165,129
Pharmaceuticals	211,305	166,883
Purchased services and other fees	123,986	90,971
Administrative services	46,834	34,661
Facilities	85,883	69,885
Insurance	20,199	17,563
	1,787,547	1,468,248
Operating income before interest, depreciation, and amortization expenses	196,323	258,851
Interest	32,601	30,845
Depreciation and amortization	116,950	100,244
Operating income before special charges	46,772	127,762
Special charges	6,507	-
Operating income	40,265	127,762
Nonoperating gains and losses		
Investment return	119,269	33,325
Derivative (losses) gains	(30,517)	22,642
Other, net	(2,034)	91
Net nonoperating gains and losses	86,718	56,058
Excess of revenues over expenses	126,983	183,820

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Total net assets at April 1, 2015	$ 6,159,310	$ 537,605	$ 286,359	$ 6,983,274
Excess of revenues over expenses	183,820	-	-	183,820
Donated capital and assets released from restrictions for capital purposes	929	(929)	-	-
Gifts and bequests	-	14,328	3,247	17,575
Transfer of net assets	163	(163)	-	-
Net investment income	-	3,455	-	3,455
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(14,899)	-	(14,899)
Retirement benefits adjustment	(757)	-	-	(757)
Change in interests in foundations	-	288	63	351
Change in value of perpetual trusts	-	-	187	187
Net change in unrealized losses on nontrading investments	292	-	-	292
Other	151	-	-	151
Increase in net assets	184,598	2,080	3,497	190,175
Total net assets at June 30, 2015	$ 6,343,908	$ 539,685	$ 289,856	$ 7,173,449
Total net assets at April 1, 2016	$ 6,603,430	$ 592,337	$ 296,822	$ 7,492,589
Excess of revenues over expenses	126,983	-	-	126,983
Donated capital and assets released from restrictions for capital purposes	3,888	(2,956)	-	932
Gifts and bequests	-	13,053	3,032	16,085
Transfer of net assets	(304)	304	-	-
Net investment income	-	2,401	-	2,401
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(11,227)	-	(11,227)
Retirement benefits adjustment	(554)	-	-	(554)
Change in interests in foundations	-	(360)	-	(360)
Change in value of perpetual trusts	-	-	(1,329)	(1,329)
Net change in unrealized gains on nontrading investments	435	-	-	435
Other	4,652	-	-	4,652
Increase in net assets	135,100	1,215	1,703	138,018
Total net assets at June 30, 2016	$ 6,738,530	$ 593,552	$ 298,525	$ 7,630,607

See notes to unaudited consolidated financial statements.

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

Operations

	Six Months Ended June 30	
	2016	2015
Unrestricted revenues		
Net patient service revenue	$ 3,714,484	$ 3,184,966
Provision for uncollectible accounts	(162,508)	(137,528)
Net patient service revenue less provision for uncollectible accounts	3,551,976	3,047,438
Other	376,831	314,571
Total unrestricted revenues	3,928,807	3,362,009
Expenses		
Salaries, wages, and benefits	2,228,299	1,849,631
Supplies	369,979	320,348
Pharmaceuticals	415,523	317,249
Purchased services and other fees	244,325	181,439
Administrative services	92,029	67,235
Facilities	173,879	138,290
Insurance	40,076	34,807
	3,564,110	2,908,999
Operating income before interest, depreciation, and amortization expenses	364,697	453,010
Interest	65,058	61,679
Depreciation and amortization	232,719	202,865
Operating income before special charges	66,920	188,466
Special charges	19,234	-
Operating income	47,686	188,466
Nonoperating gains and losses		
Investment return	132,740	159,659
Derivative losses	(64,860)	(117)
Other, net	(5,759)	(272)
Net nonoperating gains and losses	62,121	159,270
Excess of revenues over expenses	109,807	347,736

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at January 1, 2015	$5,998,053	$ 519,730	$ 284,712	$ 6,802,495
Excess of revenues over expenses	347,736	-	-	347,736
Donated capital and assets released from restrictions for capital purposes	1,298	(1,277)	-	21
Gifts and bequests	-	31,494	4,894	36,388
Transfer of net assets	199	(199)	-	-
Net investment income	-	11,335	-	11,335
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(21,686)	-	(21,686)
Retirement benefits adjustment	(1,514)	-	-	(1,514)
Change in interests in foundations	-	288	63	351
Change in value of perpetual trusts	-	-	187	187
Net change in unrealized gains on nontrading investments	(2,385)	-	-	(2,385)
Other	521	-	-	521
Increase in net assets	345,855	19,955	5,144	370,954
Balances at June 30, 2015	$6,343,908	$ 539,685	$ 289,856	$ 7,173,449
Balances at January 1, 2016	$6,627,406	$ 586,276	$ 295,316	$ 7,508,998
Excess of revenues over expenses	109,807	-	-	109,807
Donated capital and assets released from restrictions for capital purposes	5,042	(4,110)	-	932
Gifts and bequests	-	24,988	6,078	31,066
Transfer of net assets	1,606	(1,606)	-	-
Net investment income	-	7,181	-	7,181
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(18,815)	-	(18,815)
Retirement benefits adjustment	(1,109)	-	-	(1,109)
Change in interests in foundations	-	(362)	-	(362)
Change in value of perpetual trusts	-	-	(2,869)	(2,869)
Net change in unrealized losses on nontrading investments	(231)	-	-	(231)
Other	(3,991)	-	-	(3,991)
Increase in net assets	111,124	7,276	3,209	121,609
Balances at June 30, 2016	$6,738,530	$ 593,552	$ 298,525	$ 7,630,607

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Six Months Ended June 30	
	2016	2015
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 121,609	$ 370,954
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Loss on extinguishment of debt	3,925	-
Retirement benefits adjustment	1,109	1,514
Net realized and unrealized gains on investments	(118,801)	(151,619)
Depreciation and amortization	244,288	202,865
Provision for uncollectible accounts	162,508	137,528
Donated capital	(932)	(21)
Restricted gifts, bequests, investment income, and other	(35,016)	(48,261)
Accreted interest and amortization of bond premiums	(930)	(834)
Net loss (gain) in value of derivatives	52,495	(12,519)
Changes in operating assets and liabilities:		
Patient receivables	(268,661)	(147,685)
Other current assets	38,212	(23,233)
Other noncurrent assets	(24,857)	(4,667)
Accounts payable and other current liabilities	43,083	3,419
Other liabilities	22,220	(13,634)
Net cash provided by operating activities and net nonoperating gains and losses	240,252	313,807
Financing activities		
Proceeds from short-term borrowings, net	60,000	-
Proceeds from long-term borrowings	100,148	-
Payments for redemption of long-term debt	(148,260)	-
Principal payments on long-term debt	(86,826)	(58,263)
Debt issuance costs	(169)	-
Change in pledges receivables, trusts and interests in foundations	6,536	10,662
Restricted gifts, bequests, investment income, and other	35,016	48,261
Net cash (used in) provided by financing activities	(33,555)	660
Investing activities		
Expenditures for property and equipment, net	(304,025)	(181,514)
Net change in cash equivalents reported in long-term investments	(30,074)	100,280
Purchases of investments	(762,381)	(1,211,363)
Sales of investments	919,162	1,081,931
Net cash used in investing activities	(177,318)	(210,666)
Increase in cash and cash equivalents	29,379	103,801
Cash and cash equivalents at beginning of year	249,580	70,322
Cash and cash equivalents at end of period	$ 278,959	$ 174,123

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

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

2. Organization and Consolidation

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

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

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

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

3. Accounting Policies

Recent Accounting Pronouncements

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

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

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

Change in Accounting Principle

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

3. Accounting Policies (continued)

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

As a result of the adoption of ASU 2015-03, the System reclassified $22.8 million and $23.2 million from other noncurrent assets to long-term debt as of June 30, 2016 and December 31, 2015, respectively. The following table presents the impact of the change in accounting principle for debt issuance costs on the consolidated statements of operations and changes in net assets and consolidated statements of cash flows (in thousands):

	Six months Ended June 30, 2016		
	Previous Accounting Method	**Impact of Accounting Change**	**As Reported**
Consolidated Statement of Operations and Changes in Net Assets			
Interest	**$ 64,622**	**$ 436**	**$ 65,058**
Depreciation and amortization	**233,155**	**(436)**	**232,719**
Consolidated Statement of Cash Flows			
Accreted interest and amortization of bond premiums	**$ (1,366)**	**$ 436**	**$ (930)**
Depreciation and amortization	**244,724**	**(436)**	**244,288**

	Six months Ended June 30, 2015		
	Previous Accounting Method	**Impact of Accounting Change**	**As Adjusted**
Consolidated Statement of Operations and Changes in Net Assets			
Interest	$ 61,245	$ 434	$ 61,679
Depreciation and amortization	203,299	(434)	202,865
Consolidated Statement of Cash Flows			
Accreted interest and amortization of bond premiums	$ (1,268)	$ 434	$ (834)
Depreciation and amortization	203,299	(434)	202,865

4. Use of Estimates

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

5. Net Patient Service Revenue and Patient Receivables

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

	2016		2015	
Medicare	**$ 1,245,584**	**33%**	$ 950,904	30%
Medicaid	**286,766**	**8**	200,613	6
Managed care and commercial	**2,075,311**	**56**	1,917,470	60
Self-pay	**106,823**	**3**	115,979	4
	$ 3,714,484	**100%**	$ 3,184,966	100%

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

The System records an estimated provision for uncollectible accounts in the year of service for patient receivables associated with self-pay patients, including patients with deductible and copayment balances for which third-party coverage provides for a portion of the services provided. The System has experienced an increase in Medicaid revenue resulting from expansion of Medicaid eligibility in the State of Ohio and an increase in deductible and copayment balances as a result of industry trends. Self-pay write-offs increased $23.6 million in the first six months of 2016 compared to the same period in 2015. The System does not maintain a material allowance for uncollectible accounts from third-party payors.

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

6. Fair Value Measurements

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

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

- Level 1 – inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.
- Level 2 – inputs to the valuations methodology include quoted prices for similar assets or liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instrument.
- Level 3 – inputs to the valuation methodology are unobservable and significant to the fair value measurement.

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

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

The fair value of the System's pledges receivable is based on discounted cash flow analysis using treasury yield curve interest rates consistent with the maturities of the pledges receivable and adjusted for consideration of the donor's credit. The fair value of pledges receivable was $188.6 million and $185.4 million at June 30, 2016 and December 31, 2015, respectively. The carrying value of the System's pledges receivable was $175.0 million and $179.2 million at June 30, 2016 and December 31, 2015, respectively. Pledges receivable would be classified as Level 3 in the fair value hierarchy.

The fair value of the System's long-term debt is estimated by discounted cash flow analyses using current borrowing rates for similar types of borrowing arrangements and adjusted for the System's credit. Inputs, which include reported/comparable trades, broker/dealer quotes, bids and offerings, are obtained from various sources, including market participants, dealers, brokers and various news media/market information. The fair value of long-term debt was $3.5 billion at both June 30, 2016 and December 31, 2015, respectively. The carrying value of the System's long-term debt was $3.2 billion at June 30, 2016 and $3.3 billion at December 31, 2015. Long-term debt would be classified as Level 2 in the fair value hierarchy.

6. Fair Value Measurements (continued)

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

June 30, 2016	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 621,820	$ 57	$ –	$ 621,877
Fixed income securities:				
U.S. treasuries	729,033	–	–	729,033
U.S. government agencies	–	23,230	–	23,230
U.S. corporate	–	159,974	–	159,974
U.S. government agencies asset-backed securities	–	17,336	–	17,336
Corporate asset-backed securities	–	4,137	–	4,137
Foreign	–	39,929	–	39,929
Fixed income mutual funds	163,478	–	–	163,478
Common and preferred stocks:				
U.S.	398,061	1,920	–	399,981
Foreign	238,615	1,368	–	239,983
Equity mutual funds	284,487	–	–	284,487
Total cash and investments	2,435,494	247,951	–	2,683,445
Perpetual and charitable trusts	–	63,295	–	63,295
Total assets at fair value	$2,435,494	$ 311,246	$ –	$ 2,746,740
Liabilities				
Interest rate swaps	$ –	$ 202,063	$ –	$ 202,063
Foreign exchange contracts	$ –	$ 9,765	$ –	$ 9,765
Total liabilities at fair value	$ –	$ 211,828	$ –	$ 211,828

6. Fair Value Measurements (continued)

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

6. Fair Value Measurements (continued)

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

	June 30 2016	December 31 2015
Cash, cash equivalents, and investments measured at fair value	**$ 2,683,445**	$ 2,715,172
Commingled funds measured at net asset value	**2,223,554**	2,261,000
Alternative investments accounted for under the equity method	**2,344,830**	2,296,184
Pending purchases of investments	**42,000**	-
Total cash, cash equivalents, and investments	**$ 7,293,829**	$ 7,272,356
Perpetual and charitable trusts measured at fair value	**$ 63,295**	$ 65,305
Interests in foundations	**21,074**	21,436
Trusts and interests in foundations	**$ 84,369**	$ 86,741

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

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

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

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

6. Fair Value Measurements (continued)

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

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

7. Derivative Instruments

Derivative financial instruments are employed to manage risks, including interest rate and foreign currency exposures. Derivative financial instruments are reported in the consolidated balance sheets at fair value. Changes in the fair value of derivatives are recognized in derivative losses on the consolidated statement of operations and changes in net assets.

The System's objective with respect to interest rate risk is to manage the risk of rising interest rates on the System's variable rate debt and certain variable rate operating lease payments. Consistent with its interest rate risk management objective, the System entered into various interest rate swap agreements with a total outstanding notional amount of $639.8 million and $653.1 million at June 30, 2016 and December 31, 2015, respectively. During the term of these transactions, the System pays interest at a fixed rate and receives interest at a variable rate based on the London Interbank Offered Rate (LIBOR) or the Securities Industry and Financial Markets Association Index (SIFMA). The swap agreements are not designated as hedging instruments. Net interest paid or received under the swap agreements is included in derivative losses in the consolidated statements of operations and changes in net assets.

7. Derivative Instruments (continued)

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

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at June 30 2016	Notional Amount at December 31 2015
Fixed	2016	5.28%	100% of SIFMA	**$ -**	$ 4,150
Fixed	2021	3.21%	68% of LIBOR	**33,265**	34,770
Fixed	2024	3.42%	68% of LIBOR	**27,800**	28,300
Fixed	2027	3.56%	68% of LIBOR	**128,333**	132,212
Fixed	2028	5.12%	100% of LIBOR	**38,800**	39,815
Fixed	2028	3.51%	68% of LIBOR	**29,965**	30,755
Fixed	2030	5.07%	100% of LIBOR	**62,500**	62,500
Fixed	2030	5.06%	100% of LIBOR	**62,500**	62,500
Fixed	2031	3.04%	68% of LIBOR	**52,625**	53,900
Fixed	2032	4.32%	79% of LIBOR	**2,400**	2,438
Fixed	2032	4.33%	70% of LIBOR	**4,800**	4,874
Fixed	2032	3.78%	70% of LIBOR	**2,400**	2,438
Fixed	2036	4.90%	100% of LIBOR	**50,000**	50,000
Fixed	2036	4.90%	100% of LIBOR	**79,375**	79,375
Fixed	2037	4.62%	100% of SIFMA	**65,030**	65,030
				$ 639,793	$ 653,057

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

In June 2016, the System entered into five foreign currency (FX) contract agreements, expiring between September 2016 and September 2017, with a total outstanding notional amount of $150 million at June 30, 2016. The FX contract agreements are not designated as hedging instruments.

7. Derivative Instruments (continued)

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

	Derivatives Liability			
	June 30, 2016		December 31, 2015	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 202,063**	Other noncurrent liabilities	$ 159,333
Foreign currency contracts	Other noncurrent liabilities	**9,765**		-
		$ 211,828		$ 159,333

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

Derivatives not designated as hedging instruments	Location of (Loss) Gain Recognized	Quarter ended June 30 2016	Quarter ended June 30 2015	Six months ended June 30 2016	Six months ended June 30 2015
Interest rate swap agreements	Derivative (losses) gains	**$ (20,752)**	$ 22,642	**$ (55,095)**	$ (117)
Foreign currency contracts	Derivative losses	**(9,765)**	-	**(9,765)**	-
		$ (30,517)	$ 22,642	**$ (64,860)**	$ (117)

The System has used various derivative contracts in connection with certain prior obligations and investments. Although minimum credit ratings are required for counterparties, this does not eliminate the risk that a counterparty may fail to honor its obligations. Derivative contracts are subject to periodic "mark-to-market" valuations. A derivative contract may, at any time, have a positive or negative value to the System. In the event that the negative value reaches certain thresholds established in the derivative contracts, the System is required to post collateral, which could adversely affect its liquidity. At June 30, 2016 and December 31, 2015, the System posted $133.9 million and $94.1 million, respectively, of collateral with counterparties that is included in funds held by trustees in the consolidated balance sheets. In addition, if the System were to choose to terminate a derivative contract or if a derivative contract were terminated pursuant to an event of default or a termination event as described in the derivative contract, the System could be required to pay a termination payment to the counterparty.

8. Pensions and Other Postretirement Benefits

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

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

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

	Quarter Ended June 30		Six Months Ended June 30	
	2016	**2015**	**2016**	**2015**
Amounts related to defined benefit pension plans:				
Service cost	$ 545	$ 585	$ 1,089	$ 1,171
Interest cost	19,019	16,057	38,037	32,115
Expected return on assets	(19,864)	(20,596)	(39,728)	(41,191)
Net amortization and deferral	(420)	(420)	(841)	(841)
Total defined benefit pension plans	(720)	(4,374)	(1,443)	(8,746)
Defined contribution plans	54,795	50,980	112,766	102,234
	$ 54,075	**$ 46,606**	**$ 111,323**	**$ 93,488**

As of June 30, 2016, the System has made contributions of $3.2 million to the defined benefit pension plans. The System expects to fund at least $3.2 million and may make additional contributions to the defined benefit pension plans for the remainder of 2016.

9. Debt

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

10. Special Charges

The System incurred and recorded $19.2 million of special charges in 2016. Special charges is comprised of $5.4 million of statutory compensation payments related to the termination of tenant leases at 33 Grosvenor Place Limited and $13.8 million related to Lakewood Hospital and the agreement entered into between the City of Lakewood, Lakewood Hospital Association (LHA) and the Foundation in December 2015 that outlines the transition of healthcare services in the City of Lakewood. Participation in the agreement by the City of Lakewood was authorized by an ordinance adopted by Lakewood City Council. Under the terms of the agreement, the Foundation and LHA will make contributions over the next eighteen years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Foundation will construct, own and operate an approximately 62,000-square-foot family health center expected to open in 2018 that will be located adjacent to the current site of the hospital. LHA ceased inpatient operations at the hospital in February 2016, while the emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The Lakewood Hospital site is currently leased by LHA from the City of Lakewood, and clinical services at that location are operated by the Foundation since the cessation of inpatient operations. The cessation of inpatient services at the hospital is not considered a discontinued operation since the System provides inpatient hospital services at the Foundation and its subsidiary hospitals in the Northeast Ohio area.

11. Subsequent Events

The System evaluated events and transactions occurring subsequent to June 30, 2016 through August 29, 2016, the date the unaudited consolidated financial statements were issued. During this period, there were no subsequent events requiring recognition in the unaudited consolidated financial statements. In addition there were no nonrecognized subsequent events requiring disclosure, except that in August 2016 the Foundation issued private placement notes (Notes) totaling $325.0 million that were purchased by a financial institution. The Notes mature in 2046 and bear interest at a fixed rate of 3.35%. The proceeds of the Notes will be used for the general corporate purposes of the Foundation.

Unaudited Consolidating Balance Sheets

($ in thousands)

	June 30, 2016				December 31, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 198,328	$ 80,631	$ -	$ 278,959	$ 176,869	$ 72,711	$ -	$ 249,580
Patient receivables, net	988,951	94,966	(27,460)	1,056,457	879,420	94,544	(23,660)	950,304
Due from affiliates	2,632	28,012	(30,644)	-	916	40	(956)	-
Investments for current use	-	52,223	-	52,223	-	53,852	-	53,852
Other current assets	310,765	65,767	(10,112)	366,420	343,901	66,682	(2,444)	408,139
Total current assets	1,500,676	321,599	(68,216)	1,754,059	1,401,106	287,829	(27,060)	1,661,875
Investments:								
Long-term investments	5,712,532	376,954	-	6,089,486	5,813,363	371,015	-	6,184,378
Funds held by trustees	176,717	-	-	176,717	116,046	9,677	-	125,723
Assets held for self-insurance	-	113,027	-	113,027	-	93,662	-	93,662
Donor restricted assets	539,075	44,342	-	583,417	520,474	44,687	-	565,161
	6,428,324	534,323	-	6,962,647	6,449,883	519,041	-	6,968,924
Property, plant, and equipment, net	3,404,207	1,009,702	-	4,413,909	3,384,312	1,004,355	-	4,388,667
Other assets:								
Pledges receivable, net	139,847	964	-	140,811	140,137	1,331	-	141,468
Trusts and beneficial interests in foundations	75,659	8,710	-	84,369	77,416	9,325	-	86,741
Other noncurrent assets	495,023	80,777	(198,265)	377,535	325,550	81,249	(53,051)	353,748
	710,529	90,451	(198,265)	602,715	543,103	91,905	(53,051)	581,957
Total assets	$ 12,043,736	$ 1,956,075	$ (266,481)	$ 13,733,330	$ 11,778,404	$ 1,903,130	$ (80,111)	$ 13,601,423

	June 30, 2016				December 31, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable	$ 302,238	$ 73,920	$ (1,789)	$ 374,369	$ 345,228	$ 69,508	$ (2,177)	$ 412,559
Compensation and amounts withheld from payroll	312,469	45,005	-	357,474	253,615	42,053	-	295,668
Short-term borrowings	60,000	-	-	60,000	0	0	-	-
Current portion of long-term debt	169,704	5,533	-	175,237	84,392	11,302	-	95,694
Variable rate debt classified as current	397,064	62,876	-	459,940	371,825	149,135	-	520,960
Due to affiliates	110	2,663	(2,773)	-	27	929	(956)	-
Other current liabilities	361,074	114,630	(33,706)	441,998	379,854	111,115	(23,927)	467,042
Total current liabilities	1,602,659	304,627	(38,268)	1,869,018	1,434,941	384,042	(27,060)	1,791,923
Long-term debt:								
Hospital revenue bonds	2,585,102	-	-	2,585,102	2,667,806	57,954	-	2,725,760
Notes payable and capital leases	94,732	564,142	(194,817)	464,057	95,327	420,296	(49,603)	466,020
	2,679,834	564,142	(194,817)	3,049,159	2,763,133	478,250	(49,603)	3,191,780
Other liabilities:								
Professional and general insurance liability reserves	50,268	106,187	-	156,455	52,587	87,030	-	139,617
Accrued retirement benefits	424,174	66,547	-	490,721	426,180	64,573	-	490,753
Other noncurrent liabilities	490,255	77,063	(29,948)	537,370	425,155	53,197	-	478,352
	964,697	249,797	(29,948)	1,184,546	903,922	204,800	-	1,108,722
Total liabilities	5,247,190	1,118,566	(263,033)	6,102,723	5,101,996	1,067,092	(76,663)	6,092,425
Net assets:								
Unrestricted	5,958,387	783,591	(3,448)	6,738,530	5,851,045	779,809	(3,448)	6,627,406
Temporarily restricted	557,409	36,143	-	593,552	548,408	37,868	-	586,276
Permanently restricted	280,750	17,775	-	298,525	276,955	18,361	-	295,316
Total net assets	6,796,546	837,509	(3,448)	7,630,607	6,676,408	836,038	(3,448)	7,508,998
Total liabilities and net assets	$ 12,043,736	$ 1,956,075	$ (266,481)	$ 13,733,330	$ 11,778,404	$ 1,903,130	$ (80,111)	$ 13,601,423

See notes to unaudited consolidated financial statements.

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

Unaudited Consolidating Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended June 30, 2016				Three Months Ended June 30, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 1,695,342	$ 214,567	$ (56,505)	$ 1,853,404	$ 1,607,392	$ 57,400	$ (48,047)	$ 1,616,745
Provision for uncollectible accounts	(67,136)	(8,953)	-	(76,089)	(59,821)	(1,714)	-	(61,535)
Net patient service revenue less provision for uncollectible accounts	1,628,206	205,614	(56,505)	1,777,315	1,547,571	55,686	(48,047)	1,555,210
Other	160,861	81,316	(35,622)	206,555	139,700	65,899	(33,710)	171,889
Total unrestricted revenues	1,789,067	286,930	(92,127)	1,983,870	1,687,271	121,585	(81,757)	1,727,099
Expenses								
Salaries, wages, and benefits	1,026,996	148,812	(66,439)	1,109,369	928,393	52,076	(57,313)	923,156
Supplies	164,116	26,230	(375)	189,971	151,644	13,732	(247)	165,129
Pharmaceuticals	194,456	16,849	-	211,305	163,409	3,474	-	166,883
Purchased services and other fees	100,251	27,418	(3,683)	123,986	85,802	8,283	(3,114)	90,971
Administrative services	39,692	13,506	(6,364)	46,834	26,878	13,863	(6,080)	34,661
Facilities	69,302	17,571	(990)	85,883	64,780	6,519	(1,414)	69,885
Insurance	16,827	17,648	(14,276)	20,199	15,688	15,464	(13,589)	17,563
	1,611,640	268,034	(92,127)	1,787,547	1,436,594	113,411	(81,757)	1,468,248
Operating income before interest, depreciation, and amortization expenses	177,427	18,896	-	196,323	250,677	8,174	-	258,851
Interest	30,302	2,299	-	32,601	30,246	599	-	30,845
Depreciation and amortization	99,356	17,594	-	116,950	95,020	5,224	-	100,244
Operating income (loss) before special charges	47,769	(997)	-	46,772	125,411	2,351	-	127,762
Special charges	-	6,507	-	6,507	-	-	-	-
Operating income (loss)	47,769	(7,504)	-	40,265	125,411	2,351	-	127,762
Nonoperating gains and losses								
Investment return	110,536	8,733	-	119,269	32,215	1,110	-	33,325
Derivative (losses) gains	(29,832)	(685)	-	(30,517)	23,401	(759)	-	22,642
Other, net	7	(2,041)	-	(2,034)	93	(2)	-	91
Net nonoperating gains and losses	80,711	6,007	-	86,718	55,709	349	-	56,058
Excess (deficiency) of revenues over expenses	128,480	(1,497)	-	126,983	181,120	2,700	-	183,820

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

($ in thousands)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at April 1, 2015	$ 6,456,278	$ 530,444	$ (3,448)	$ 6,983,274
Excess of revenues over expenses	181,120	2,700	-	183,820
Restricted gifts and bequests	17,204	371	-	17,575
Restricted net investment income	3,218	237	-	3,455
Net assets released from restrictions used for operations included in other unrestricted revenues	(10,858)	(4,041)	-	(14,899)
Contributions from (to) affiliates	231	(231)	-	-
Retirement benefits adjustment	(757)	-	-	(757)
Change in restricted net assets related to interests in foundations	186	165	-	351
Change in restricted net assets related to value of perpetual trusts	148	39	-	187
Net change in unrealized gains on nontrading investments	292	-	-	292
Other	(349)	500	-	151
Increase (decrease) in total net assets	190,435	(260)	-	190,175
Total net assets at June 30, 2015	$ 6,646,713	$ 530,184	$ (3,448)	$ 7,173,449
Total net assets at April 1, 2016	$ 6,662,854	$ 833,183	$ (3,448)	$ 7,492,589
Excess (deficiency) of revenues over expenses	128,480	(1,497)	-	126,983
Donated capital, excluding assets released from restrictions for capital purposes	932	-	-	932
Restricted gifts and bequests	15,530	555	-	16,085
Restricted net investment income	1,764	637	-	2,401
Net assets released from restrictions used for operations included in other unrestricted revenues	(10,588)	(639)	-	(11,227)
Transfers (to) from affiliates	(522)	522	-	-
Retirement benefits adjustment	(554)	-	-	(554)
Change in restricted net assets related to interests in foundations	(362)	2	-	(360)
Change in restricted net assets related to value of perpetual trusts	(1,141)	(188)	-	(1,329)
Net change in unrealized gains on nontrading investments	435	-	-	435
Other	(282)	4,934	-	4,652
Increase in total net assets	133,692	4,326	-	138,018
Total net assets at June 30, 2016	$ 6,796,546	$ 837,509	$ (3,448)	$ 7,630,607

See notes to unaudited consolidated financial statements.

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

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

Operations

	Six Months Ended June 30, 2016				Six Months Ended June 30, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 3,390,406	$ 435,156	$ (111,078)	$ 3,714,484	$ 3,166,028	$ 117,676	$ (98,738)	$ 3,184,966
Provision for uncollectible accounts	(142,432)	(20,076)	-	(162,508)	(133,315)	(4,213)	-	(137,528)
Net patient service revenue less provision for uncollectible accounts	3,247,974	415,080	(111,078)	3,551,976	3,032,713	113,463	(98,738)	3,047,438
Other	303,041	143,810	(70,020)	376,831	266,297	112,743	(64,469)	314,571
Total unrestricted revenues	3,551,015	558,890	(181,098)	3,928,807	3,299,010	226,206	(163,207)	3,362,009
Expenses								
Salaries, wages, and benefits	2,063,960	294,668	(130,329)	2,228,299	1,861,017	103,926	(115,312)	1,849,631
Supplies	319,630	50,809	(460)	369,979	298,648	21,972	(272)	320,348
Pharmaceuticals	382,378	33,145	-	415,523	309,402	7,847	-	317,249
Purchased services and other fees	197,436	53,103	(6,214)	244,325	172,044	15,409	(6,014)	181,439
Administrative services	76,556	27,912	(12,439)	92,029	50,317	28,575	(11,657)	67,235
Facilities	139,737	36,156	(2,014)	173,879	128,094	12,970	(2,774)	138,290
Insurance	33,408	36,310	(29,642)	40,076	31,397	30,588	(27,178)	34,807
	3,213,105	532,103	(181,098)	3,564,110	2,850,919	221,287	(163,207)	2,908,999
Operating income before interest, depreciation, and amortization expenses	337,910	26,787	-	364,697	448,091	4,919	-	453,010
Interest	60,337	4,721	-	65,058	60,522	1,157	-	61,679
Depreciation and amortization	196,965	35,754	-	232,719	192,690	10,175	-	202,865
Operating income (loss) before special charges	80,608	(13,688)	-	66,920	194,879	(6,413)	-	188,466
Special charges	969	18,265	-	19,234	-	-	-	-
Operating income (loss)	79,639	(31,953)	-	47,686	194,879	(6,413)	-	188,466
Nonoperating gains and losses								
Investment return	121,013	11,727	-	132,740	151,392	8,267	-	159,659
Derivative (losses) gains	(63,432)	(1,428)	-	(64,860)	1,410	(1,527)	-	(117)
Other, net	277	(6,036)	-	(5,759)	(219)	(53)	-	(272)
Net nonoperating gains and losses	57,858	4,263	-	62,121	152,583	6,687	-	159,270
Excess (deficiency) of revenues over expenses	137,497	(27,690)	-	109,807	347,462	274	-	347,736

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

Changes in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2015	$ 6,273,610	$ 532,333	$ (3,448)	$ 6,802,495
Excess of revenues over expenses	347,462	274	-	347,736
Donated capital, excluding assets released from restrictions for capital purposes	21	-	-	21
Restricted gifts and bequests	35,926	462	-	36,388
Restricted net investment income	10,771	564	-	11,335
Net assets released from restrictions used for operations included in other unrestricted revenues	(17,264)	(4,422)	-	(21,686)
Contributions from (to) affiliates	231	(231)	-	-
Retirement benefits adjustment	(1,514)	-	-	(1,514)
Change in restricted net assets related to interest in foundations	186	165	-	351
Change in restricted net assets related to value of perpetual trusts	148	39	-	187
Net change in unrealized losses on nontrading investments	(2,385)	-	-	(2,385)
Other	(479)	1,000	-	521
Increase (decrease) in total net assets	373,103	(2,149)	-	370,954
Total net assets at June 30, 2015	$ 6,646,713	$ 530,184	$ (3,448)	$ 7,173,449
Total net assets at January 1, 2016	$ 6,676,408	$ 836,038	$ (3,448)	$ 7,508,998
Excess (deficiency) of revenues over expenses	137,497	(27,690)	-	109,807
Donated capital, excluding assets released from restrictions for capital purposes	932	-	-	932
Restricted gifts and bequests	30,119	947	-	31,066
Restricted net investment income	6,363	818	-	7,181
Net assets released from restrictions used for operations included in other unrestricted revenues	(17,435)	(1,380)	-	(18,815)
Transfers (to) from affiliates	(32,871)	32,871	-	-
Retirement benefits adjustment	(1,109)	-	-	(1,109)
Change in restricted net assets related to interests in foundations	(362)	-	-	(362)
Change in restricted net assets related to value of perpetual trusts	(2,279)	(590)	-	(2,869)
Net change in unrealized losses on nontrading investments	(231)	-	-	(231)
Other	(486)	(3,505)	-	(3,991)
Increase in total net assets	120,138	1,471	-	121,609
Total net assets at June 30, 2016	$ 6,796,546	$ 837,509	$ (3,448)	$ 7,630,607

See notes to unaudited consolidated financial statements.

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

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Six Months Ended June 30, 2016				Six Months Ended June 30, 2015			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Operating activities and net nonoperating gains and losses								
Increase (decrease) in total net assets	$ 120,138	$ 1,471	$ -	$ 121,609	$ 373,103	$ (2,149)	$ -	$ 370,954
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities and net nonoperating gains and losses:								
Gain on extinguishment of debt	-	3,925	-	3,925	-	-	-	-
Retirement benefits adjustment	1,109	-	-	1,109	1,514	-	-	1,514
Net realized and unrealized gains on investments	(108,781)	(10,020)	-	(118,801)	(143,623)	(7,996)	-	(151,619)
Depreciation and amortization	196,965	47,323	-	244,288	192,690	10,175	-	202,865
Provision for uncollectible accounts	142,432	20,076	-	162,508	133,315	4,213	-	137,528
Donated capital	(932)	-	-	(932)	(21)	-	-	(21)
Restricted gifts, bequests, investment income, and other	(33,841)	(1,175)	-	(35,016)	(47,031)	(1,230)	-	(48,261)
Transfers to (from) affiliates	32,871	(32,871)	-	-	(231)	231	-	-
Accreted interest and amortization of bond premiums	(932)	2	-	(930)	(840)	6	-	(834)
Net loss in value of derivatives	59,376	(6,881)	-	52,495	(12,519)	-	-	(12,519)
Changes in operating assets and liabilities:								
Patient receivables	(251,963)	(20,498)	3,800	(268,661)	(146,944)	(1,974)	1,233	(147,685)
Other current assets	27,642	(26,786)	37,356	38,212	(31,412)	(58,458)	66,637	(23,233)
Other noncurrent assets	(170,421)	350	145,214	(24,857)	(7,404)	-	2,737	(4,667)
Accounts payable and other current liabilities	36,837	17,454	(11,208)	43,083	9,020	33,738	(39,339)	3,419
Other liabilities	290	51,878	(29,948)	22,220	(14,649)	29,546	(28,531)	(13,634)
Net cash provided by operating activities and net nonoperating gains and losses	50,790	44,248	145,214	240,252	304,968	6,102	2,737	313,807
Financing activities								
Proceeds from short-term borrowings, net	60,000	-	-	60,000	-	-	-	-
Proceeds from long-term borrowings	100,000	145,362	(145,214)	100,148	-	2,737	(2,737)	-
Payments for advance refunding of long-term debt	-	(148,260)	-	(148,260)	-	-	-	-
Principal payments on long-term debt	(79,160)	(7,666)	-	(86,826)	(55,363)	(2,900)	-	(58,263)
Debt issuance costs	(169)	-	-	(169)	-	-	-	-
Change in pledges receivable, trusts and interests in foundations	5,825	711	-	6,536	7,309	3,353	-	10,662
Restricted gifts, bequests, investment income, and other	33,841	1,175	-	35,016	47,031	1,230	-	48,261
Net cash provided by (used in) financing activities	120,337	(8,678)	(145,214)	(33,555)	(1,023)	4,420	(2,737)	660
Investing activities								
Expenditures for property and equipment	(247,137)	(56,888)	-	(304,025)	(176,321)	(5,193)	-	(181,514)
Net change in cash equivalents reported in long-term investments	(71,229)	41,155	-	(30,074)	92,899	7,381	-	100,280
Purchases of investments	(663,159)	(99,222)	-	(762,381)	(1,015,134)	(196,229)	-	(1,211,363)
Sales of investments	864,728	54,434	-	919,162	903,223	178,708	-	1,081,931
Transfers (to) from affiliates	(32,871)	32,871	-	-	231	(231)	-	-
Net cash used in investing activities	(149,668)	(27,650)	-	(177,318)	(195,102)	(15,564)	-	(210,666)
(Decrease) increase in cash and cash equivalents	21,459	7,920	-	29,379	108,843	(5,042)	-	103,801
Cash and cash equivalents at beginning of year	176,869	72,711	-	249,580	2,952	67,370	-	70,322
Cash and cash equivalents at end of period	$ 198,328	$ 80,631	$ -	$ 278,959	$ 111,795	$ 62,328	$ -	$ 174,123

See notes to unaudited consolidated financial statements.

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

Utilization

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

CLEVELAND CLINIC HEALTH SYSTEM

	Year Ended December 31			YTD June 30	
	2013	**2014**	**2015[4]**	**2015[3]**	**2016**
Total Staffed Beds[1]	3,535	3,565	4,034	4,035	3,858
Percent Occupancy[1]	67.7%	67.0%	68.0%	68.3%	69.6%
Inpatient Admissions[1]					
Acute	145,199	140,596	147,031	81,341	81,145
Post-acute	11,801	11,908	11,762	7,209	6,345
Total	157,000	152,504	158,793	88,550	87,490
Patient Days[1]					
Acute	759,553	746,293	787,161	426,767	423,532
Post-acute	99,205	99,701	97,956	60,146	52,800
Total	858,758	845,994	885,117	486,913	476,332
Average Length of Stay					
Acute	5.24	5.28	5.31	5.25	5.22
Post-acute	8.40	8.38	8.30	8.30	8.40
Surgical Facility Cases					
Inpatient	57,084	55,515	56,529	30,448	30,004
Outpatient	131,659	130,706	137,125	72,329	73,820
Total	188,743	186,221	193,654	102,777	103,824
Emergency Room Visits	475,777	497,631	542,418	311,549	324,559
Outpatient Observations	43,416	49,724	49,665	28,808	28,094
Outpatient Evaluation and Management Visits[2]	2,926,084	3,077,939	3,279,097	1,623,939	1,823,715
Acute Medicare Case Mix Index - Health System	1.87	1.90	1.91	1.90	1.96
Acute Medicare Case Mix Index - Cleveland Clinic	2.50	2.47	2.47	2.49	2.50
Total Acute Patient Case Mix Index - Health System	1.78	1.81	1.81	1.81	1.87
Total Acute Patient Case Mix Index - Cleveland Clinic	2.35	2.37	2.36	2.37	2.41

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

Utilization (continued)

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

TOTAL OBLIGATED GROUP

	Year Ended December 31			YTD June 30	
	2013	**2014**	**2015**	**2015**	**2016**
Total Staffed Beds[1]	3,260	3,297	3,352	3,318	3,345
Percent Occupancy[1]	69.0%	68.2%	69.7%	70.0%	70.7%
Inpatient Admissions[1]					
Acute	138,697	134,704	138,256	68,511	70,096
Post-acute	9,564	9,827	9,752	4,910	4,848
Total	148,261	144,531	148,008	73,421	74,944
Patient Days[1]					
Acute	734,783	722,977	751,700	372,013	375,787
Post-acute	70,666	71,989	73,576	36,714	38,326
Total	805,449	794,966	825,276	408,727	414,113
Surgical Facility Cases					
Inpatient	55,085	53,764	53,845	27,028	27,196
Outpatient	128,521	127,903	132,787	65,259	67,723
Total	183,606	181,667	186,632	92,287	94,919
Emergency Room Visits	442,113	464,981	494,037	241,343	265,700
Outpatient Observations	40,476	46,409	45,680	23,502	24,052
Outpatient Evaluation and Management Visits[2]	2,926,084	3,077,939	3,279,097	1,623,939	1,823,715
Acute Medicare Case Mix Index	1.83	1.85	1.86	1.90	1.96
Total Acute Patient Case Mix Index	1.74	1.76	1.76	1.81	1.87

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

(2) Statistic is calculated based on Cleveland Clinic only.

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

Payor Mix

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

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

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

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD June 30	
	2013	2014	2015	2015	2016
Payor					
Managed Care and Commercial	43%	44%	42%	42%	40%
Medicare	43%	42%	43%	43%	44%
Medicaid	8%	10%	12%	12%	13%
Self-Pay & Other	6%	4%	3%	3%	3%
Total	100%	100%	100%	100%	100%

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

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

Research Support

($ in thousands)

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

	Year Ended December 31			YTD June 30	
	2013	**2014**	**2015**	**2015**	**2016**
External Grants Earned					
Federal Sources	$106,211	$97,327	$103,022	$48,635	$53,972
Non-Federal Sources	72,255	88,284	81,796	37,426	42,655
Total	178,466	185,611	184,818	86,061	96,627
Internal Support	67,259	66,758	63,240	33,987	28,732
Total Sources of Support	$245,725	$252,369	$248,058	$120,048	$125,359

Key Ratios

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

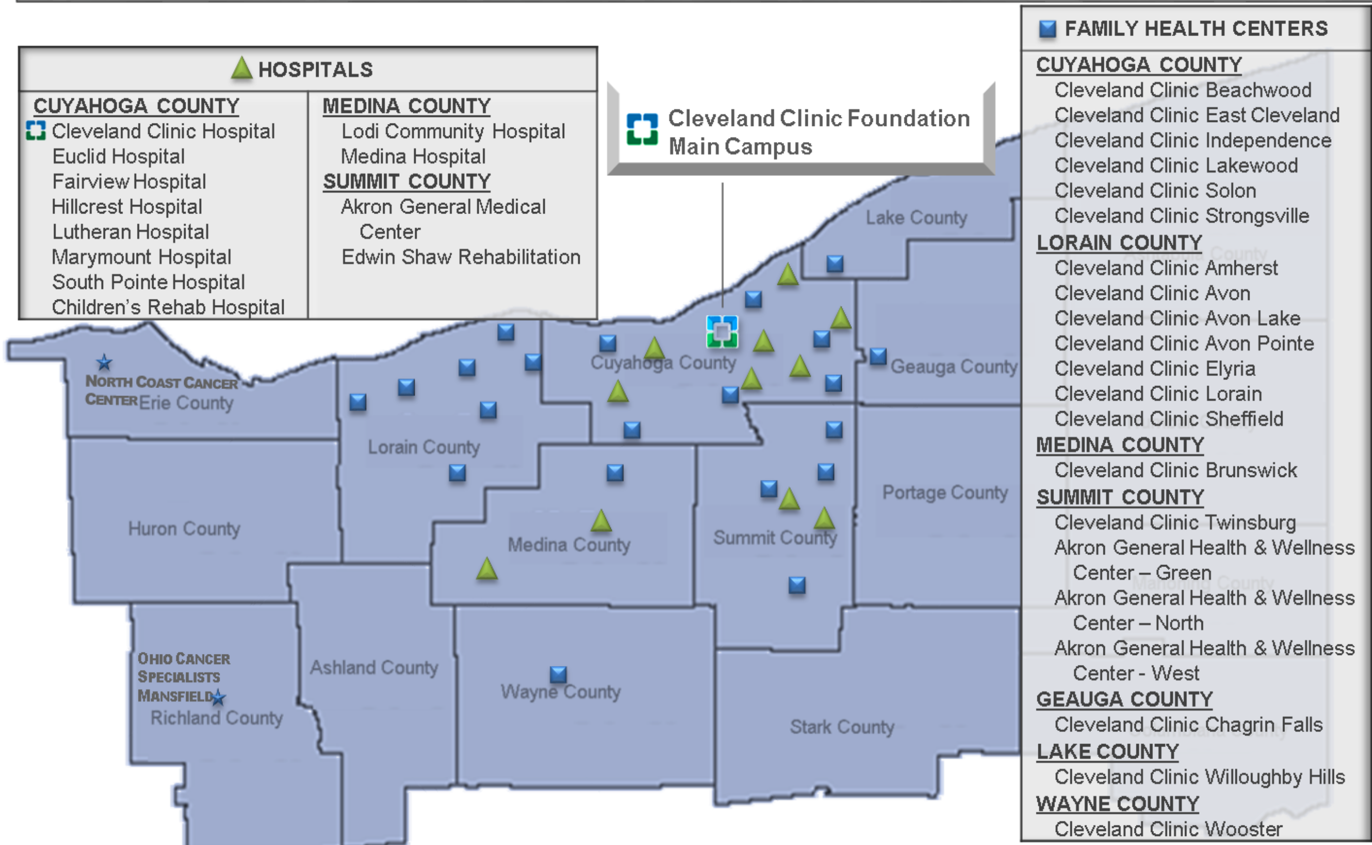
	Year Ended December 31			YTD June 30	
	2013	2014	2015	2015	2016
Liquidity ratios					
Days of cash on hand	323	377	347	394	325
Days of revenue in accounts receivable	48	47	47	49	55
Coverage ratios					
Cash to debt (%)	173.8	177.5	168.9	189.0	170.1
Maximum annual debt service coverage (x)	5.6	5.6	5.7	5.9	5.6
Interest expense coverage (x)	10.3	11.1	10.0	10.8	9.5
Debt to cash flow (x)	2.9	3.0	3.4	2.9	3.4
Leverage ratio					
Debt to capitalization (%)	35.0	36.1	36.5	34.6	35.7
Profitability ratios					
Operating margin (%)	4.6	7.0	6.7	5.6	1.2
Operating cash flow margin (%)	11.7	14.4	14.7	13.5	9.3
Excess margin (%)	12.8	10.2	8.5	9.9	2.8
Return on assets (%)	8.2	5.7	4.5	5.5	1.6

NOTES:

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

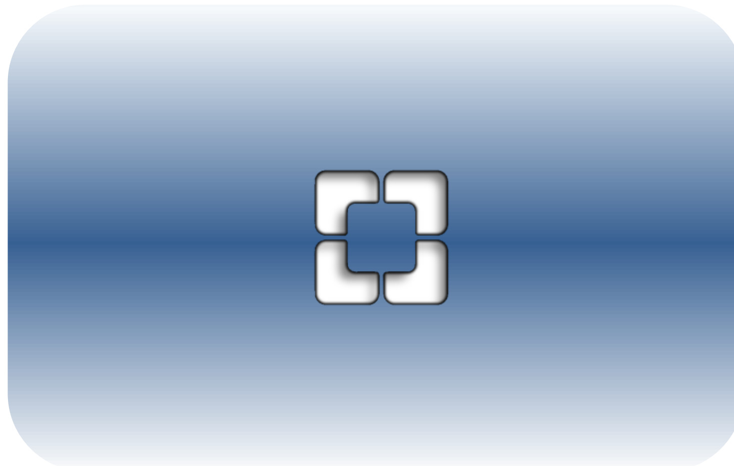
OVERVIEW

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



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

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,274
Euclid Hospital	221
Fairview Hospital	451
Hillcrest Hospital	453
Lutheran Hospital	194
Marymount Hospital	286
Medina Hospital	136
South Pointe Hospital	175
Weston Hospital	155
	3,345
NON-OBLIGATED	
Akron General Medical Center	433
Lodi Hospital	20
Edwin Shaw Rehabilitation Institute	35
Children's Rehab Hospital	25
	513
HEALTH SYSTEM	3,858



AWARDS & RECOGNITION

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

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

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

Category	Rank
In the "HONOR ROLL"	
Cleveland Clinic	2nd
Ranked No. 1	
Cardiology & Heart Surgery	1st
In America's Top 3	
Gastroenterology & GI Surgery	2nd
Nephrology	2nd
Urology	2nd
Diabetes & Endocrinology	3rd
Gynecology	3rd
Orthopedics	3rd
Pulmonology	3rd
Rheumatology	3rd
In America's Top 15	
Neurology & Neurosurgery	6th
Cancer	8th
Geriatrics	8th
Ophthalmology	8th
Ear, Nose & Throat	12th

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

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

BEST CHILDREN'S HOSPITALS
U.S.News & WORLD REPORT
RANKED IN 9 SPECIALTIES
2016-17

Pediatric Ranking by Specialty

Specialty	Rank
Gastroenterology & GI Surgery	19th
Neurology & Neurosurgery	19th
Cardiology & Heart Surgery	23rd
Pulmonology	23rd
Urology	26th
Orthopedics	27th
Nephrology	37th
Cancer	39th
Diabetes & Endocrinology	46th

The publication also evaluated hospitals by state and metropolitan area with a methodology similar to that used to determine the national rankings. The Clinic was ranked as the best hospital in both the state of Ohio and the Cleveland metropolitan area, which includes the City of Cleveland and its surrounding suburbs. The report also ranked two of the System's regional hospitals in the top hospitals in the Cleveland metropolitan area and Ohio: Fairview Hospital ranked third in Cleveland and fourth in Ohio and Hillcrest Hospital ranked fifth in Cleveland and twelfth in Ohio. Akron General Medical Center, located in Summit County, was ranked ninth out of about 215 hospitals in the list of top hospitals in state of Ohio. Weston Hospital was ranked first in the Miami-Fort Lauderdale metro area and fifth out of more than 250 hospitals in the state of Florida.

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

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

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

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

Five of the System's hospitals saw an improvement in their Spring 2016 Hospital Safety Scores from Leapfrog Group, an organization that publishes semi-annual safety grades to help consumers make informed decisions when choosing a hospital. Three regional hospitals, including Euclid, Lutheran and Medina Hospitals, received an "A" hospital safety score, which is the highest score provided by the Leapfrog Group. The Hospital Safety Score combines national performance measures from the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, and the American Hospital Association's Annual Survey and Health Information Technology Supplement. The System is committed to providing the safest, highest quality patient care by continuing to identify and adopt evidence-based practices that are designed to eliminate patient harm, improve outcomes and enhance the patient experience.

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

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

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

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

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

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

CORPORATE GOVERNANCE

The Board of Directors of the Clinic is responsible for all of its operations and affairs and controls its property. The Board of Directors is also responsible for ensuring that the Clinic is organized, and at all times operated, consistent with its charitable mission and its status as an Ohio nonprofit corporation and tax-exempt charitable organization. The Board of Directors generally meets eight times per year, including an annual meeting during which the Clinic's officers are elected and standing committees are appointed. The size of the Board of Directors can range between 15 to 25 Directors (currently there are 22 Directors). The Board of Trustees serves as an advisor to the Board of Directors. The Trustees actively serve on the committees of the Board of Directors. At present, there are 82 active Trustees and 11 Emeritus Trustees (not including Directors). Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

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

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

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

APPOINTMENTS

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

Janice G. Murphy, RN, MSN, FACHE was appointed Acting President of Akron General while a search is being conducted to replace Thomas Stover, MD, who retired in May 2016. Ms. Murphy is the current Chief Operating Officer for Cleveland Clinic Regional Hospitals and Family Health Centers. She has also previously served as Chief Operating Officer of Sheikh Khalifa Medical City in Abu Dhabi and the president of Fairview Hospital for seven years.

Jorge Guzman, MD was appointed Vice President of Regional Hospital Medical Operations. Dr. Guzman most recently served as the Director of the Medical Intensive Care Unit at the Clinic and Director of Intensive Care Unit Operations for the System. He has served in many leadership positions at the Clinic and nationally.

Josh Miller, DO was appointed Vice President of Regional Family Health Center Operations. Dr. Miller most recently served as the Medical Director of the Willoughby Hills Family Health Center and as Medical Director of the Madison and Mentor medical office buildings. Previously, he was Medical Director of the Strongsville Family Health and Surgery Center.

In collaboration with System leadership, Dr. Guzman and Dr. Miller will be responsible for integrating regional hospitals and family health centers and driving strategy for integrated programs and services in Medical Operations.

LAKEWOOD HOSPITAL ASSOCIATION

The Lakewood Hospital Association (LHA) is a non-obligated affiliate of the System. The Clinic, LHA and the City of Lakewood entered into an agreement in December 2015 that outlines the transition of healthcare services in the City of Lakewood and how the Clinic can be a leader in meeting those healthcare needs. Participation in the agreement by the City of Lakewood was authorized by an ordinance adopted by Lakewood City Council.

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

Prior to the signing of the agreement, a lawsuit was filed against the Clinic, LHA, the City of Lakewood and others (Defendants) by a few Lakewood residents (Plaintiffs) seeking to stop the closure of the hospital and money damages. To date, the court has denied the Plaintiffs' Motion for a Temporary Restraining Order. The Plaintiffs' Motion for a Preliminary Injunction is still pending. The Defendants jointly filed Motions to Dismiss the lawsuit. In November 2015, Lakewood voters defeated a proposed charter amendment that would have required voter approval on any Lakewood City Council ordinance that would have caused the hospital to no longer be a full time and full service hospital. As a result of duly signed petitions, a referendum vote to repeal the ordinance will occur in November 2016, but the City's Law Director has publicly opined that the referendum vote would not affect the implementation of the agreement, which has been partially performed and remains binding upon its parties.

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:

Radiology Master Plan - This multi-year, five-phase renovation and construction plan is aimed at fulfilling the growth needs of the Department of Radiology within the Imaging Institute. The project will consolidate and centralize magnetic resonance (MR) services for the Clinic in the Glickman Tower located on the Clinic's main campus. The project also includes the renovation of vacated molecular functional imaging space into a new Computed Tomography (CT) department including sub-waiting, prep, changing, and hydration. Additionally, the plan allows for a new outpatient entrance to the Department of Radiology and enhanced patient waiting and changing areas. Phase 1A of the project, the Interventional MR Surgical Suite, began in 2009 and was completed in 2010. The Suite combines high-field MR imaging with a surgical suite, which allows surgeons to

take advantage of MR imaging in real time during surgical procedures. Phase 1B, the consolidation of MR services in the Glickman Tower, began in the fourth quarter 2010 and was completed in July 2011. Phase 2, the consolidation of CT services, was completed in the third quarter of 2013. Phase 3, the relocation and upgrade of the Interventional Radiology Department, began in the third quarter of 2013 and was completed in the first quarter of 2015. Phase 4 began in the fourth quarter of 2015, and phase 5 is expected to begin in the fourth quarter of 2016. These phases include thirty hard-walled and ten curtained holding rooms, a preparation and recovery area, a newly renovated ultrasound department that includes adult and pediatric scanning, a state of the art myelogram room, gastrointestinal department and general diagnostic departments with sub-waiting and changing areas. The entire project is expected to be completed in 2018 with a total estimated cost of approximately $86 million.

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

New Cancer Outpatient Building – In 2013, the System started programming and design of a new Cancer Outpatient Building. The new building will be located on the Clinic's main campus, adjacent to the Crile Outpatient Building and across from the new Tomsich Pathology Laboratories Building. The 377,000 square foot, seven-story building is expected to house 126 exam rooms, 98 infusion bays, 6 linear accelerators, 7 procedure rooms, a Gamma Knife and other support functions for the Clinic's cancer program. The building will unite multidisciplinary surgical, medical, and support services for cancer at the main campus in one facility. The estimated cost of the new building is $276 million. Construction started in the third quarter of 2014 and is expected to be completed in the first quarter of 2017.

Main Campus Structured Parking Garage – With the anticipated increase in patient services provided by the new Cancer Outpatient Building, the System began design in 2014 of a 3,000 space structured parking garage to be located on the southeast corner of the main campus. The garage will be exclusively for employees, allowing current employee parking to be designated for patients and visitors. The garage is expected to cost approximately $45 million and be completed in late 2016.

Enterprise Administrative Patient Management - The System is currently in the midst of a multi-year project to align revenue cycle support services and processes to support patients as they progress through their continuum of care. The Enterprise Administrative Patient Management (EAPM) project will consolidate thirteen different technology systems used for scheduling appointments, admissions, electronic medical records, billing and collections into one technology platform with the goal of improving patient experiences. Reducing the number of systems will improve patient service and employee

efficiency. Implementation of EAPM began in the first quarter of 2012 at the System facilities in Weston, Florida. The Clinic's main campus and family health centers implemented EAPM in the first quarter of 2016. Implementation will continue in phases for the other System hospitals over the next several years and is expected to cost approximately $191 million over the entire implementation period.

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

Coral Springs Family Health Center and Surgery Center - Cleveland Clinic Florida is expecting to expand its services in a new Family Health Center and Surgery Center that will be built on land previously purchased in Coral Springs, Florida. Coral Springs is approximately twenty miles northeast of the Weston campus. This new 72,000 square foot facility will accommodate approximately forty exam rooms, four operating rooms with shell space for two additional operating rooms in the future, two endoscopy rooms and imaging services. The full scope and cost for the facility have not been finalized. Design began in the second quarter of 2016, and construction is projected to be completed in the second quarter of 2018.

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

Lakewood Family Health Center – In January 2016, the Clinic started design of a new approximately 62,000 square foot, three story family health center in Lakewood on a site adjacent to the recently closed Lakewood Hospital. The facility will have an emergency department located on the first floor with 20 treatment rooms. On the second and third floors, the facility will have approximately 60 exam rooms. There will also be lab and imaging services to support operations at the facility. The facility is projected to cost approximately $37 million and is scheduled to open in June 2018.

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

PHILANTHROPY CAMPAIGN

The Clinic publicly launched "The Power of Every One" philanthropic campaign in June 2014 with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the Clinic to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. As of June 30, 2016, the Clinic has raised almost $906 million toward the goal.

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

INNOVATIONS

Cleveland Clinic Innovations promotes scientific, clinical and administrative creativity throughout the System and seeks commercial application of the products of that creativity. Specifically, it helps to grow the Clinic's innovative capacity, mentors inventors,

licenses technology, secures resources, and establishes spin-off companies and strategic collaborations with corporate partners. Since 2000, 76 companies, of which more than 40 are currently active, have been spun-off from the Clinic with Cleveland Clinic Innovations entering into more than 450 technology licenses, filing over 2,900 patent applications with over 850 issued patents, and acting on approximately 3,600 new inventions.

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

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

In 2016, Cleveland Clinic Innovations entered into four development agreements with one of its industry alliance partners. Under these agreements the Clinic and the commercial partner agree to work together to further develop technologies for the purpose of bringing them to market.

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

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

Cleveland Clinic Innovations hosts an annual Medical Innovation Summit for industry leaders, investors, and entrepreneurs looking to expand their understanding of the healthcare market and the future of medical innovation. The 13th annual Summit was held in October 2015 with the focus on the neuroscience healthcare market. The 14th Annual Medical Innovation Summit is scheduled for October 2016 and will focus on investable innovation in the context of healthcare's historic transformation.

CLINICAL AFFILIATIONS

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

strategies. In addition, the Clinic has partnered with educational institutions with the goal of improving medical education and research.

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

In August 2016, the Clinic's Endocrinology and Metabolism Institute entered into an affiliation with the National Diabetes and Obesity Research Institute (NDORI) to enhance diabetes and obesity related research and discover better treatment protocols. This is the first affiliation for the Clinic's Endocrinology and Metabolism Institute. NDORI was founded in 2015 by a group of health care, education and business leaders in Mississippi with the hopes of finding a cure for diabetes. NDORI will be part of a 150-acre learning medical city located in Tradition, Mississippi. Once the affiliation is fully implemented, NDORI patients will have greater access to better practices related diabetes and obesity treatments.

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

STRATEGIC ALLIANCES

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

JOINT VENTURE

Under a joint venture agreement with Select Medical, the Cleveland Clinic Rehabilitation Hospital opened in December 2015 in Avon, Ohio. Select Medical is the nation's largest provider of post-acute care services and has partnerships with academic medical centers around the country. The Clinic is a minority member in the joint venture. The new

68,000 square foot facility has 60 beds and features private rooms and the latest rehabilitation equipment to care for patients with stroke, spinal cord injury, brain injury, and a variety of medical and surgical conditions. The facility expands inpatient rehabilitation services in Northeast Ohio and improves access for patients with complex rehabilitation needs. The hospital will also serve as a primary teaching site for a new residency program for physicians in physical medicine and rehabilitation. The two organizations also entered into a management agreement that became effective in August 2014 to enhance inpatient rehabilitation operations in existing System facilities.

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

AKRON GENERAL HEALTH SYSTEM

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

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

consolidated financial statements.

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

INTERNATIONAL GROWTH

On October 13, 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. Grosvenor Place currently leases office space to various tenants. The Clinic has established a plan to convert the building to a healthcare facility upon receiving the necessary approvals from local authorities.

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

STRATEGY

The System is focused on building a business model that drives improvement in outcomes and cost (value-based). This represents a shift from the long-standing model of providing care and billing for services (volume-based). While the System has long been committed to providing the highest quality of care with a focus on patients first, the formula for success in a value-based world requires equal focus on cost and adherence to prescriptive measurement and comparative reporting.

Unsustainable economic trends, an aging population, dramatic increases in chronic disease, dissatisfaction with access, technological transparency to cost and quality information and legislative efforts have all contributed to the need for new models of healthcare delivery and payment.

Transitioning to a value-based care model, while managing reimbursement pressures and investment requirements, is a challenge requiring creativity and commitment. Through integrated facilities and engaged caregivers and leaders, the System is innovating its care and business model to be even more patient-centered, evidence-based, efficient and uniform.

Targeted areas of effort include:

- Care Paths across the continuum to reduce practice variation, improve quality outcomes, lower costs and improve efficiency – multiple pilots are currently underway to test Care Paths in practice, with goals of quality improvement and cost reduction

- Development of a Medicare ACO, expansion of the Center for Medicare and Medicaid Innovation bundled payment initiative and participation in shared savings agreements with commercial health plans to incentivize improved outcomes - collaborative discussions are underway with major health plans as the System transitions from a fee-based to a value-based payment structure
- Clinical integration programs, like the Quality Alliance, to further incorporate care protocols and measurements beyond the Clinic's physician group
- Advanced technology infrastructure to enhance predictive capabilities and knowledge management
- Cost reduction, resource rationalization and asset optimization to drive efficiency

The System continues to focus on cost saving initiatives that are designed to increase value and make healthcare affordable to patients. Despite inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System has experienced solid cost management primarily through implementation of Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. As part of this focus, management continues to evaluate existing operations at System facilities and explore opportunities for creating greater efficiencies through consolidation and redeployment of System assets.

To continually operate in a lower cost structure while maintaining or improving performance, the System is compelled to grow in non-traditional ways. Through both owned and affiliated relationships, the System expects to continue to pursue growth opportunities that optimize its regional assets, increase its national and international presence and maximize efficiency. Growth considerations include contracting with large employers, commercial health plan based accountable care organizations, payors and other delivery systems to provide clinical products of proven value.

The System believes it is uniquely positioned to not only succeed but to lead in the changing healthcare environment. Previous organizational changes and investments have laid the groundwork for this new, integrated care model. Adopting an aligned institute structure, strengthening measurement and reporting capabilities, piloting population management programs and declaring an intent to build "One Cleveland Clinic" are all being leveraged and incorporated into the System's new strategy.

COMMUNITY BENEFIT AND ECONOMIC IMPACT

Community Benefit

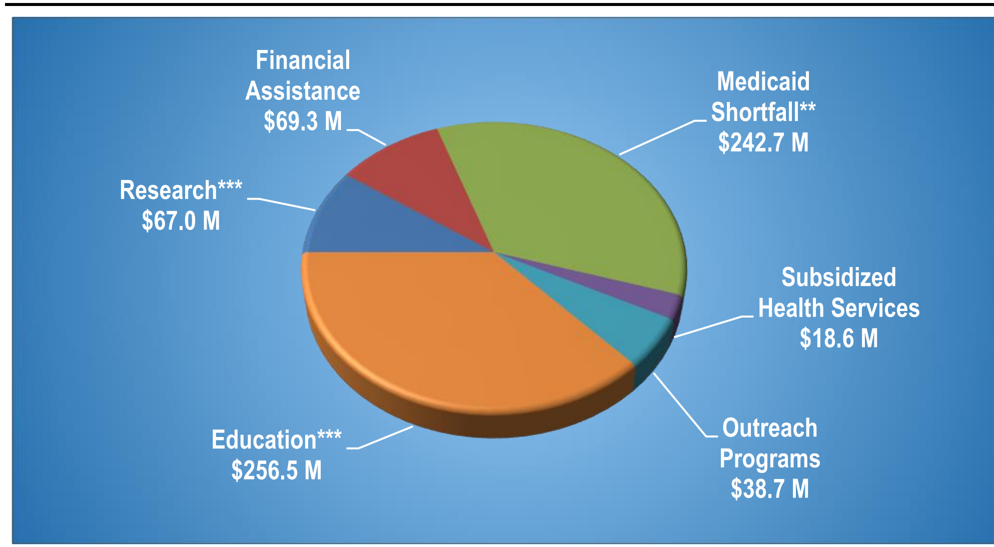
The Clinic and its hospital affiliates within the System are comprised of charitable, tax-exempt healthcare organizations. The System's mission includes addressing health service needs and providing benefits to the communities it serves. The tax-exempt members of the System must satisfy a community benefit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

exempt status. Community benefit reporting for the System conforms to Internal Revenue Service requirements.

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

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

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



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

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

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

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

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

- The System provided no-cost clinical care to under- and uninsured families at community sites. The Langston Hughes Health and Education Center, a Fairfax neighborhood site, provided multigenerational prevention and wellness services.
- Health fairs provided thousands of people with free screenings for diabetes, cholesterol, heart disease, and prostate and various cancers. The Cleveland Clinic Minority Men's Health Fair, Celebrating Sisterhood, Tu Familia and dozens of community health fairs educated community members on the benefits of preventive healthcare.
- Community education classes were offered across the enterprise on chronic disease management in the areas of heart disease, stroke, cancer, diabetes and brain health.
- Wellness initiatives and health lectures were provided to schools, faith-based organizations and community centers in the areas of prevention and behavioral change, including smoking cessation, weight management, teen parenting, family violence and child safety.
- Physical education, training and concussion awareness were provided to high school students by the Clinic's Orthopaedic and Rheumatology Institute. The Pediatric Mobile Unit provided wellness services to local elementary schools.
- The Clinic's Robert J. Tomsich Pathology & Laboratory Medicine Institute donated services to The Free Clinic and Care Alliance, Cleveland area safety-net providers.

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

College of Medicine of Case Western Reserve University, dedicated to the teaching of physician-scientists.

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

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

Community Health Needs Assessment

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

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

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

Information has and will be gathered from persons representing the broad interests of the community, including those with special knowledge or expertise in public health.

Key CHNA needs identified throughout the System include:

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

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

Economic Impact

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

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

SUSTAINABILITY

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

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

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

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

Environmental Protection Agency and Practice Greenhealth.

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

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

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

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

In May 2016, the Clinic announced the establishment of a $7.5 million Green Revolving Fund (GRF), which is the largest established fund of its kind in the healthcare industry and one of the largest in any business sector nationally. GRF funds invest in energy efficiency projects to reduce energy consumption. Savings achieved from reduced energy consumption and any rebates received are tracked and used to replenish the GRF fund to invest in future

projects. The establishment of the GRF fund is part of the Sustainable Endowments Institute's Billion Dollar Green Challenge. The challenge encourages colleges, universities and other nonprofit institutions to invest in self-managed green revolving funds. The Clinic's GRF fund will help drive the Clinic's continued commitment to energy conservation and overall sustainability, including the goals set forth by the Better Buildings Challenge.

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

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

DIVERSITY

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

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

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

HEALTH INFORMATION TECHNOLOGY

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

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

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

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

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

The System utilizes a grant accounting model to recognize EHR incentive revenues. Under this model, the System records EHR incentive revenue ratably throughout the incentive reporting period when it is reasonably assured that it will meet the meaningful use objectives for the required reporting period and that the grants will be received. The System recorded EHR incentive revenues of $2.4 million for the six months ended June 30, 2016 and has recorded a total of $141 million since the inception of the program. Throughout the program, the System is expected to receive approximately $146 million in EHR incentive payments.

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

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

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

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

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

CONFLICT OF INTEREST

The System maintains policies that require internal reporting of outside financial and fiduciary interests to ensure that potential conflicts of interests do not inappropriately influence research, patient care, education, business or professional decision making. In connection with these policies, the System developed the Innovation Management and Conflict of Interest Program, which is designed to promote innovation while at the same time reducing, eliminating or managing real or perceived bias either due to System personnel

consulting with pharmaceutical, medical device and diagnostic companies (industry) or the commercialization efforts undertaken by the System to develop discoveries and make them accessible to patients. The Program works with investigators who interact with industry to manage any conflicts. Provisions related to whether or not "compelling circumstances" are required to justify conducting research in the presence of related financial interests have been modified in policies that went into effect in 2013, consistent with the value the System places on beneficial relationships with industry. The System is committed to a process that maintains integrity in innovation and places the interests of our patients first.

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

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

The System maintains a Conflict of Interest in Education Policy to reflect its values and represent its and its Staff's best interests. This policy is responsive to guidelines from the Association of American Medical Colleges, the Institute of Medicine and other organizations. It places restrictions on outside speaking activities that are not Accreditation Council for Continuing Medical Education approved and are generally considered marketing. Speakers must present content that is data-driven and balanced; speakers must create their own slides or use only unbranded slides created by industry. This policy puts the System in step with other top academic medical centers that have already banned speaker's bureaus. In addition, the policy requires instructors to disclose relevant financial interests with companies to trainees.

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

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

ENTERPRISE RISK MANAGEMENT

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

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

INTERNAL CONTROLS OVER FINANCIAL REPORTING

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

INDUSTRY OUTLOOK

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

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

The System continues to be impacted by industry challenges that put pressure on the System's financial performance. Management is focused on the recruitment and retention of qualified staff in many clinical areas in order to meet the demands of patient activity, particularly as the Affordable Care Act health insurance mandates and Medicaid expansion programs have been implemented that have increased the number of insured Americans seeking healthcare services. These efforts pressure the System's salary cost structure, as well as employee benefit costs. Pharmaceutical costs and medical supply costs continue to create challenges to the cost structure. Increases in pharmaceutical costs are driven by utilization, price increases and the specialized nature of many pharmaceuticals used in oncology and hematology. Medical supply costs are primarily driven by utilization and price of implants. For both pharmaceuticals and medical supplies, a sizeable percentage of the cost increase flows through to increases in payments from payors; however, the balance cannot be passed through to payors. Additionally, the healthcare industry is subject to significant regulation by federal, state, and local governmental agencies and independent organizations and accrediting bodies, changes in technology and treatment modes, competition and changes in third-party reimbursement programs. The decline in the population of the Greater Cleveland area, as noted in the 2013 census, creates challenges among hospitals to attract patients. Furthermore, although the System maintains a diversified investment portfolio, the System's investments are subject to the inherent risk and volatility associated with global financial markets. The System continuously monitors the environment in which it operates and is engaged in various strategic initiatives to address its cost structure and reimbursement challenges to make healthcare affordable to patients.

PATIENT VOLUMES

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

Utilization Statistics

	For the quarter ended June 30				For the six months ended June 30			
	2016	2015	Variance	%	2016	2015	Variance	%
Inpatient admissions[1]								
Acute admissions	40,277	41,363	-1,086	-2.6%	81,145	81,341	-196	-0.2%
Post-acute admissions	3,137	3,591	-454	-12.6%	6,345	7,209	-864	-12.0%
	43,414	44,954	-1,540	-3.4%	87,490	88,550	-1,060	-1.2%
Patient days[1]								
Acute patient days	208,473	213,412	-4,939	-2.3%	423,532	426,767	-3,235	-0.8%
Post-acute patient days	26,617	29,739	-3,122	-10.5%	52,800	60,146	-7,346	-12.2%
	235,090	243,151	-8,061	-3.3%	476,332	486,913	-10,581	-2.2%
Surgical cases								
Inpatient	14,866	15,201	-335	-2.2%	30,004	30,448	-444	-1.5%
Outpatient	37,355	37,052	303	0.8%	73,820	72,329	1,491	2.1%
	52,221	52,253	-32	-0.1%	103,824	102,777	1,047	1.0%
Emergency department visits	164,425	160,526	3,899	2.4%	324,559	311,549	13,010	4.2%
Observations	14,494	14,052	442	3.1%	28,094	28,808	-714	-2.5%
Clinic outpatient evaluation and management visits	913,500	828,791	84,709	10.2%	1,823,715	1,623,939	199,776	12.3%

[1] Excludes newborns

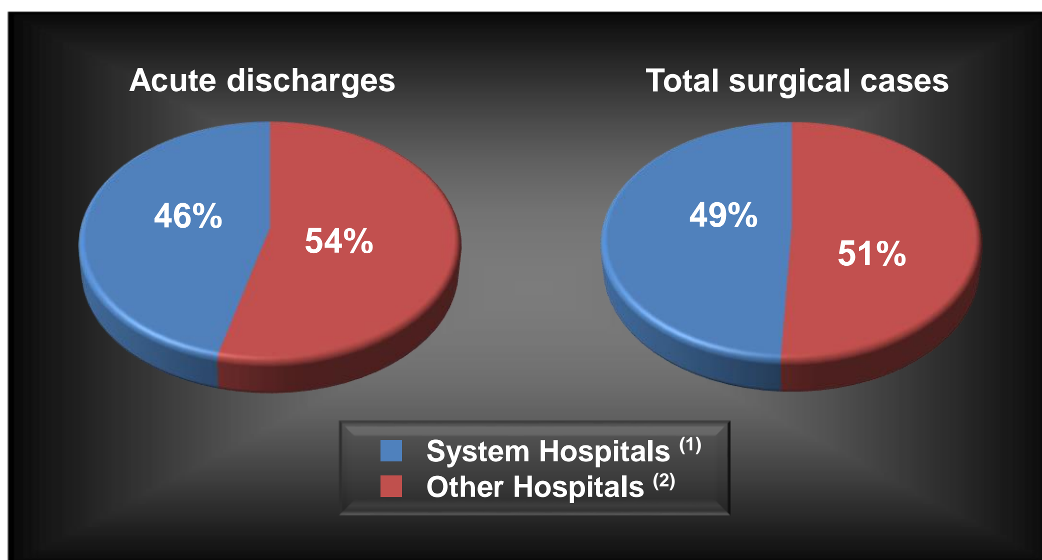
Proforma inpatient acute admissions for the System decreased 3% in the second quarter of 2016 and were flat in the first six months of 2016 compared to the same periods in 2015. In the first six months of 2016, the Clinic experienced a 1% decrease in acute admissions and the regional hospitals, which includes Akron General, collectively experienced flat acute admissions. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio service area decreased 2% in the first six months of 2016 compared to the same period in 2015. The Florida facilities experienced a 1% increase in acute admissions.

Proforma post-acute admissions for the System decreased 13% in the second quarter of 2016 and decreased 12.0% in the first six months of 2016 compared to the same periods in 2015. The decrease was primarily due to the cessation of inpatient services at Lakewood Hospital.

Proforma total surgical cases for the System were flat in the second quarter of 2016 and increased 1% in the first six months of 2016 compared to the same periods in 2015. For the first six months of 2016, the increase was driven by a 1% increase at the Clinic's main campus and family health centers and a 6% increase at

the Florida facilities. Total surgical cases at the regional hospitals collectively were flat in the first six months of 2016 compared to the same period in 2015. According to data from the Center for Health Affairs, total surgical cases in northeast Ohio increased 3% in the first six months of 2016 compared to the same period in 2015. The surgical mix of proforma total surgical cases for the System for the first six months of 2016 was 29% inpatient and 71% outpatient, which represents an approximately 1% shift from inpatient to outpatient compared to the surgical mix in the first six months of 2015.

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



Source: The Center for Health Affairs Volume Statistics

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

LIQUIDITY

Cash and Investments

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

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

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

Cash and Investments
(Dollars in thousands)

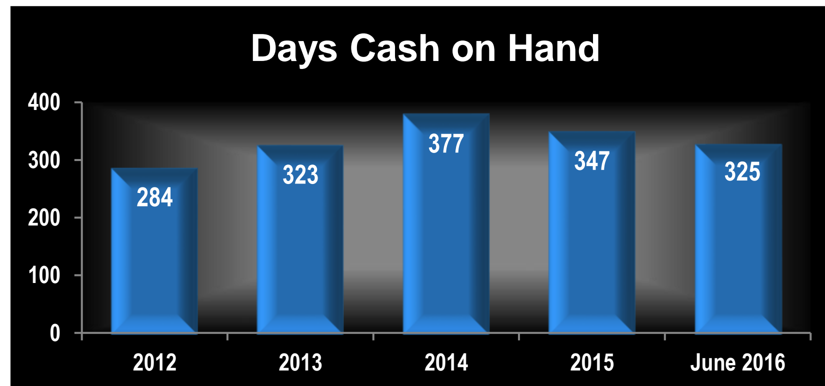
	June 30, 2016			December 31, 2015		
Cash and cash equivalents	$	621,877	8%	$	562,406	8%
Fixed income securities*		1,788,099	25%		1,909,853	26%
Marketable equity securities*		2,539,023	35%		2,503,913	33%
Alternative investments		2,344,830	32%		2,296,184	32%
Total cash and investments		7,293,829	100%		7,272,356	99%
Less restricted investments**		(925,384)			(838,398)	
Unrestricted cash and investments	$	6,368,445		$	6,433,958	
Days cash on hand		325			347	

* Fixed income securities and marketable equity securities include mutual funds and commingled investment funds within each investment allocation category.

** Restricted investments include funds held by trustees, assets held for self-insurance and donor restricted assets.

Twinsburg Family Health Center
Twinsburg, Ohio

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



At June 30, 2016, total cash and investments for the System (including restricted investments) were $7.294 billion, an increase of $22 million from $7.272 billion at December 31, 2015. Cash inflows consist of cash provided by operating activities and related investment income of $359 million, a net increase in restricted gifts and income of $42 million, and net proceeds from the issuance of short and long-term borrowings of $12 million. Cash inflows were offset by net capital expenditures of $304 million and scheduled principal payments on debt of $87 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $165.2 million at June 30, 2016, with an asset mix of 15% cash and short-term investments, 43% fixed-income securities, 28% equity investments and 14% alternative investments. The asset mix reflects the need for liquidity and the objective to maintain stable returns utilizing a lower tolerance for risk and volatility consistent with insurance regulatory requirements.

Also included in the System's cash and investments at June 30, 2016 are $176.7 million of funds held by trustees. Funds held by trustees include $162.1 million of posted collateral. Collateral is comprised of $28.2 million related to a futures and options program within the System's investment portfolio and $133.9 million related to the System's derivative contracts. The derivative contracts require that collateral be posted when the market value of a contract in a liability position exceeds a certain threshold. The collateral is returned as the liability is reduced. The System also has $11.7 million of funds held by the bond trustee resulting from the issuance of the Series 2014A Taxable Hospital Revenue Commercial Paper Notes (Series 2014A CP Notes) and $2.9 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 June 30, 2016, the asset mix of funds held by trustees was 23% cash and short-term investments and 77% fixed-income securities.

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

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

Alternative Investments
(Dollars in thousands)

	June 30, 2016			December 31, 2015		
Hedge funds	$	1,304,545	56%	$	1,350,427	59%
Private equity/venture capital		595,161	25%		541,009	24%
Real estate		445,124	19%		404,748	17%
Total alternative investments	$	2,344,830	100%	$	2,296,184	100%

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

Investment Return

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

The System's long-term investment portfolio, which excludes assets held for self-insurance, reported investment gains of 1.2% for the second quarter of 2016, which is lower than the portfolio's benchmark gain of 1.7% and higher than investment losses of 0.2% experienced in the second quarter of 2015. For the first six months of 2016, the System experienced investment gains of 1.5%, which is lower than the portfolio's benchmark gain of 3.4% and lower than the investment gains of 2.5% experienced for the first six months of 2015.

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

Investment Return
(Dollars in thousands)

	For the quarter ended June 30		For the six months ended June 30	
	2016	2015	2016	2015
Other unrestricted revenue:				
Interest income and dividends	$ 724	$ 900	$ 1,338	$ 1,182
Nonoperating gains and losses, net:				
Interest income and dividends	16,179	14,171	28,047	23,127
Net realized gains (losses) on sales of investments	4,086	41,115	(5,503)	79,338
Net change in unrealized gains (losses) on investments	80,104	(48,334)	118,332	12,643
Equity method income on alternative investments	23,717	30,312	1,573	52,685
Investment management fees	(4,817)	(3,939)	(9,709)	(8,134)
	119,269	33,325	132,740	159,659
Other changes in net assets:				
Net change in unrealized gains (losses) on nontrading investments	435	292	(231)	(2,385)
Investment income on restricted investments	2,401	3,455	7,181	11,335
Total investment return	$ 122,829	$ 37,972	$ 141,028	$ 169,791

Pension Investments

In 2014, the System updated its investment strategy and modified the allocation of pension plan investments in the CCHS Retirement Plan (Plan), the System's primary defined benefit pension plan. The Plan ceased benefit accruals for substantially all employees as of December 31, 2009, and ceased benefit accruals for remaining employees at various intervals through December 31, 2012. As of December 31, 2015, the Plan had investments of $1.1 billion, which was 87% of the projected benefit obligation. Coincident with the updated investment strategy the System reduced the asset allocation for common and preferred stocks with a corresponding increase in fixed income securities. The updated investment strategy was implemented because of the funded status of the Plan and the anticipation that such changes in investment strategy will result in lower volatility of future changes in funded status. Once the new investment strategy is fully implemented, it is anticipated that the duration of the investment assets will match the liabilities of the Plan over time. Additional revisions in asset allocations may occur based on future changes in the funded status of the Plan. As of June 30, 2016, the Plan's investments totaled $1.1 billion, which was comprised of 7% cash and cash equivalents, 45% fixed-income investments, 28% equities, and 20% alternative investments.

Long-term Debt

At June 30, 2016, outstanding hospital revenue bonds for the System totaled $3.174 billion, comprised of $2.376 billion (75%) of fixed-rate bonds, $11 million (<1%) of index-rate bonds and $787 million (25%) of variable-rate bonds. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds and certain variable-rate operating lease payments. The total notional amount on the System's interest rate swap contracts at June 30, 2016 was $640 million. Using an interest rate benchmark, these contracts convert variable-rate debt to a fixed-rate, which further reduces the System's exposure to variable interest rates. The interest rate swap contracts can be unwound by the System at any time, whereas the counterparty has the option to unwind the contracts only upon an event of default as defined in the contracts.

Approximately $375 million of the variable-rate bonds are secured by irrevocable direct pay letters of credit or standby bond purchase agreements. Bonds are classified as current liabilities if they are supported by letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year, or contain a subjective clause that, if declared by the lender, could cause immediate repayment of the bonds.

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

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

Combined current aggregate scheduled principal payments by calendar year, assuming the remarketing of the variable-rate bonds for the five years subsequent to December 31, 2015, are as follows (in millions): 2016 – $60.8; 2017 – $65.6; 2018 – $68.0; 2019 – $71.4; and 2020 – $73.9. The System has paid $58.8 million of regularly scheduled principal payments in the first six months of 2016.

Euclid Medical Office
Euclid, Ohio

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

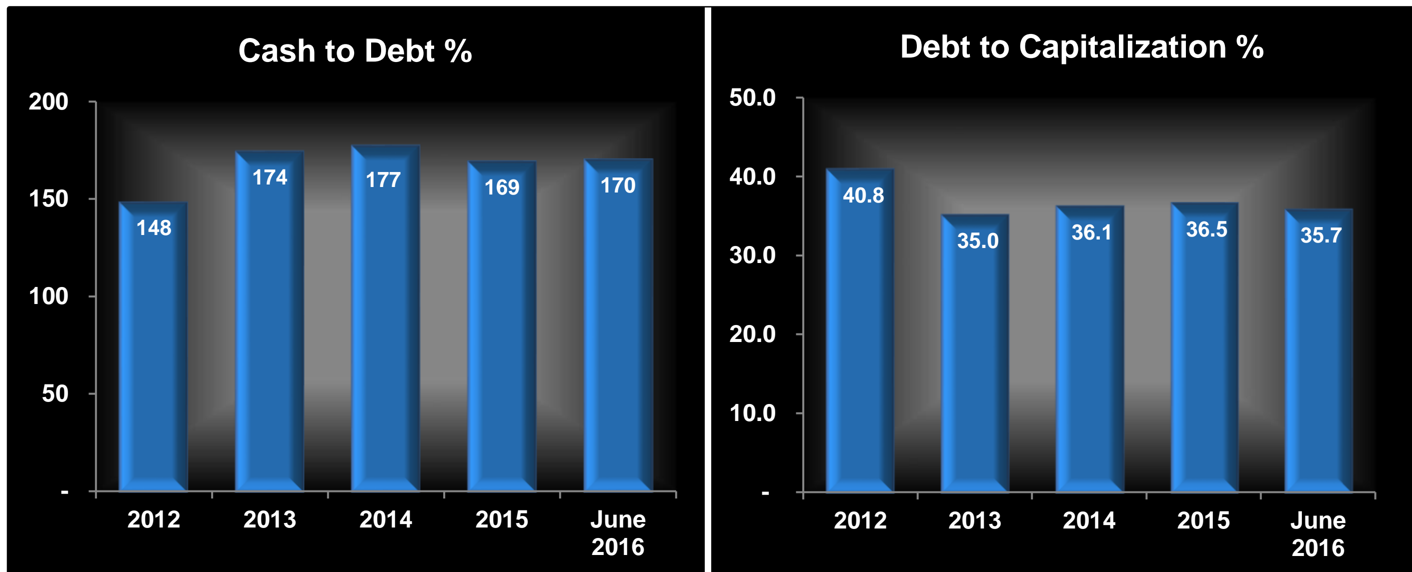
Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	June 30 2016	December 31 2015
2014	CCHS Obligated Group	Fixed	2114	$ 400,000	$ 400,000
2014A	CCHS Obligated Group	CP Notes	2044	100,000	-
2014A	Akron General	Variable	2031	-	70,925
2014B	Akron General	Variable	2031	-	20,000
2013A	CCHS Obligated Group	Fixed / Index	2042	73,150	81,225
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	65,030	65,030
2012A	CCHS Obligated Group	Fixed	2039	460,080	469,485
2012TEFR	Akron General	Fixed	2031	-	39,835
2012TVR	Akron General	Variable	2031	-	17,370
2011A	CCHS Obligated Group	Fixed	2032	172,030	181,180
2011B	CCHS Obligated Group	Fixed	2031	29,120	31,250
2011C	CCHS Obligated Group	Fixed	2032	170,995	170,995
2009A	CCHS Obligated Group	Fixed	2039	305,400	305,400
2009B	CCHS Obligated Group	Fixed	2039	366,215	380,455
2008A	CCHS Obligated Group	Fixed	2043	409,740	419,690
2008B	CCHS Obligated Group	Variable	2043	369,250	369,250
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
2002	CCHS Obligated Group	Variable	2032	9,790	9,940
				$ 3,173,865	$ 3,275,095

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

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

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



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

Cleveland Clinic Main Campus
Cleveland, Ohio

BOND RATINGS

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

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

Bond Ratings

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

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

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

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended June 30, 2016 and 2015

Operating income for the System in the second quarter of 2016 was $40.3 million, resulting in an operating margin of 2.0%, as compared to operating income of $127.8 million and an operating margin of 7.4% in the second quarter of 2015. On a same facility basis (excluding Akron General operating loss of $1.2 million and Grosvenor Place operating loss of $5.8 million), operating income for the System for the second quarter of 2016 was $47.3 million, resulting in an operating margin of 2.6%. The lower operating income on a same facility basis for the second quarter of 2016 primarily resulted from a 9.6% increase in total operating expenses, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs, administrative services and purchased services and other fees. The System also recorded $6.5 million in special charges in the second quarter of 2016 related to non-recurring expenses for Grosvenor Place and the transition of healthcare services in the City of Lakewood. Same facility unrestricted revenues increased 4.3% primarily due to increased outpatient volumes and a strong case mix despite lower inpatient activity. Nonoperating gains for the

System were $86.7 million in the second quarter of 2016 compared to nonoperating gains of $56.1 million in the second quarter of 2015. The increase from the prior year was primarily a result of gains and losses on investments attributable to overall changes in the financial markets partially offset by an unfavorable variance in derivative gains and losses. Overall, the System reported an excess of revenues over expenses of $127.0 million in the second quarter of 2016, or $132.0 million on a same facility basis, compared to an excess of revenues over expenses of $183.8 million in the second quarter of 2015.

The System's net patient service revenue increased $236.7 million (14.6%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, net patient service revenue increased $54.0 million (3.3%). The System experienced same facility decreases in inpatient acute admissions of 3.8% and inpatient surgical cases of 2.7% in the second quarter of 2016 compared to the second quarter of 2015. Same facility outpatient volumes increased in the second quarter of 2016 compared to the first quarter of 2015 as outpatient evaluation and management visits at the Clinic increased 10.2%, emergency department visits increased 2.6% and outpatient surgical cases increased 1.0%. The System has also experienced an increase in Medicaid revenue partially due to expansion of Medicaid eligibility in the State of Ohio, which has increased enrollment in the Medicaid program. The State of Ohio expanded the program effective January 1, 2014, which has allowed former uninsured patients to shift into the expanded Medicaid program. Governmental and self-pay revenue as a percentage of total gross patient revenue has increased more than 1% in the second quarter of 2016 compared to the same period in 2015, with a corresponding decrease in managed care and commercial gross revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2016. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts increased $14.6 million (23.7%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, provision for uncollectible accounts increased $6.7 million (10.9%). The increase is primarily attributable to increases in net patient service revenue and in deductible and copayment balances. The growth in high deductible health plans is an industry trend that will likely continue to accelerate, particularly as patients enroll in a health plan on the newly formed exchanges offered under the Affordable Care Act. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances continue to grow and are more difficult to collect than traditional insurance payors. Management continues to monitor the changing healthcare environment and resulting impact on the System and is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare affordable to patients.

Other unrestricted revenues increased $34.7 million (20.2%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, other unrestricted revenues increased $26.4 million (15.4%). The increase in same facility revenues was primarily due to a $20.2 increase in international contract management revenue, a $14.5 million increase in outpatient pharmacy revenue, and a $7.1 million increase in revenue related to research and education grants. These increases were

offset by $10.9 million of revenue recorded in 2015 related to the sale of a Cleveland Clinic Innovations spin-off company and $2.6 million of equity earnings related to the System's investment in Akron General prior to the member substitution.

Total operating expenses increased $344.3 million (21.5%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, total operating expenses increased $154.2 million (9.6%). Included in this increase are special charges of $1.1 million related to Lakewood Hospital and the transition of healthcare services in the City of Lakewood, Ohio, and a $16.2 million increase in costs related to a specialty pharmacy. In 2015 the System implemented salary adjustments to caregivers in nursing and other clinical institutes. The System also experienced an increase in purchased service expenses and consulting expenses related to certain strategic projects and initiatives. Despite the growth in expenses caused by increased patient volumes and inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System experienced solid cost management primarily through implementation of Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. Management continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries and benefits increased $186.2 million (20.2%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, salaries and benefits increased $86.4 million (9.4%). Same facility salaries, excluding benefits, increased $81.8 million (10.4%) due to annual salary adjustments averaging 1-2% across the System that were awarded in the second quarter of 2016 and a 4.6% increase in average full-time equivalent employees in the second quarter of 2016 compared to the same period in 2015. The System has also invested in its caregivers in 2015 by increasing the minimum wage across the System, increasing the starting salary for nurses and providing salary adjustments to current caregivers in nursing and other clinical institutes. Same facility employee benefit costs increased $4.6 million (3.4%). The System experienced a $7.6 million increase in retirement benefit expenses and a $4.8 million increase in FICA expenses. These increases were offset by a $6.6 million decrease in employee and retiree health care costs.

Supplies expense increased $24.8 million (15.0%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, supplies expense increased $7.7 million (4.7%). The System experienced an $8.9 million increase in same facility implantables and other medical supplies and a $1.2 million decrease in same facility non-medical supplies. To address the challenge of rising supply and service costs in the healthcare industry, management is engaged in an organizational transformation program to identify and implement clinical and non-clinical savings initiatives through renegotiation, product standardization, utilization changes and improvements in procurement to payment processes.

Pharmaceutical costs increased $44.4 million (26.6%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, pharmaceutical costs increased $30.7 million (18.4%). The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to

treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $16.2 million in the second quarter of 2016 compared to the same period in 2015. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $33.0 million (36.3%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, purchased services and other fees increased $13.1 million (14.4%). The increase in same facility purchased service expenses was primarily due to increased costs related to certain System projects, including the EAPM implementation at the Clinic's main campus and family health centers and new technology for the Human Resources Department.

Administrative services increased $12.2 million (35.1%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, administrative services increased $7.9 million (22.9%). The increase in same facility administrative services was primarily due to an increase in consulting fees and other professional services of $4.4 million related to certain strategic initiatives of the System, an increase in travel and professional education expenses of $2.1 million and an increase in expenses related to research activities of $1.7 million.

Facilities expense increased $16.0 million (22.9%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, facilities expense increased $3.6 million (5.1%). The increase in same facility facilities expense was primarily due to an increase in repairs and maintenance costs across the System.

Insurance expense increased $2.6 million (15.0%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, insurance expense increased $0.4 million (2.3%). The increase in same facility insurance expense was primarily due to an increase in professional malpractice expense. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense increased $1.8 million (5.7%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, interest expense decreased $0.1 million (0.2%). The System made $86.8 million of principal payments on bonds, notes and capital leases in 2016, which reduced the amount of interest due on outstanding debt. This was partially offset by interest incurred on the Series 2014A CP Notes and a $60 million draw on a line of credit, which occurred in January 2016.

Depreciation and amortization expenses increased $16.7 million (16.7%) in the second quarter of 2016 compared to the same period in 2015. On a same facility basis, depreciation and amortization expenses increased $3.4 million (3.4%). Changes in depreciation include property, plant and equipment that was fully

depreciated in 2015, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2016.

The System incurred and recorded $6.5 million of special charges in the second quarter of 2016. Special charges in the second quarter of 2016 are comprised of $5.4 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place and $1.1 million related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a detailed description of the terms of the agreement, refer to "LAKEWOOD HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $86.7 million in the second quarter of 2016 compared to $56.1 million in 2015. Investment returns were favorable by $85.9 million in the second quarter of 2016 compared to the same period in 2015. The System's long-term investment portfolio reported investment gains of 1.2% for the second quarter of 2016, which is lower than the portfolio's benchmark gain of 1.7% but higher than investment losses of 0.2% experienced in the second quarter of 2015. Derivative losses were unfavorable by $53.2 million in the second quarter of 2016 compared to the same period in 2015. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements.

For the Six Months Ended June 30, 2016 and 2015

Operating income for the System in the first six months of 2016 was $47.7 million, resulting in an operating margin of 1.2%, as compared to operating income of $188.5 million and an operating margin of 5.6% in the first six months of 2015. On a same facility basis (excluding Akron General operating loss of $1.6 million and Grosvenor Place operating loss of $5.9 million), operating income for the System for the first six months of 2016 was $55.2 million, resulting in an operating margin of 1.5%. The lower operating income on a same facility basis for the first six months of 2016 primarily resulted from a 10.5% increase in total operating expenses, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs, administrative services and purchased services and other fees. The System also recorded $19.2 million in special charges in the first six months of 2016 related to non-recurring expenses for Grosvenor Place and the transition of healthcare services in the City of Lakewood. Same facility unrestricted revenues increased 6.0% primarily due to increased outpatient volumes and a strong case mix despite lower inpatient activity. Nonoperating gains for the System were $62.1 million in the first six months of 2016 compared to nonoperating gains of $159.3 million in the first six months of 2015. The decrease from the prior year was primarily a result of gains and losses on investments attributable to overall changes in the financial markets and an unfavorable variance in derivative gains and losses. Overall, the System reported an excess of revenues over expenses

of $109.8 million in the first six months of 2016, or $115.8 million on a same facility basis, compared to an excess of revenues over expenses of $347.7 million in the first six months of 2015.

The System's net patient service revenue increased $529.5 million (16.6%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, net patient service revenue increased $163.9 million (5.1%). The System experienced same facility decreases in inpatient acute admissions of 1.3% and inpatient surgical cases of 2.0% in the first six months of 2016 compared to the same period in 2015. Same facility outpatient volumes increased in the first six months of 2016 compared to the same period in 2015 as outpatient evaluation and management visits at the Clinic increased 12.3%, emergency department visits increased 4.7% and outpatient surgical cases increased 2.1%. The System has also experienced an increase in Medicaid revenue partially due to expansion of Medicaid eligibility in the State of Ohio, which has increased enrollment in the Medicaid program. Governmental and self-pay revenue as a percentage of total gross patient revenue has increased more than 1% in the first six months of 2016 compared to the same period in 2015, with a corresponding decrease in managed care and commercial gross revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2016. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts increased $25.0 million (18.2%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, provision for uncollectible accounts increased $7.6 million (5.6%). The increase is primarily attributable to increases in net patient service revenue and in deductible and copayment balances. The growth in high deductible health plans is an industry trend that will likely continue to accelerate, particularly as patients enroll in a health plan on the newly formed exchanges offered under the Affordable Care Act. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances continue to grow and are more difficult to collect than traditional insurance payors. Management continues to monitor the changing healthcare environment and resulting impact on the System and is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare affordable to patients.

Other unrestricted revenues increased $62.3 million (19.8%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, other unrestricted revenues increased $44.8 million (14.2%). The increase in same facility revenues was primarily due to a $32.4 million increase in outpatient pharmacy revenue, a $23.1 increase in international contract management revenue, a $9.0 million increase in revenue related to research and education grants. These increases were offset by $10.9 million of revenue recorded in 2015 related to the sale of a Cleveland Clinic Innovations spin-off company and $3.1 million of equity earnings related to the System's investment in Akron General prior to the member substitution.

Total operating expenses increased $707.6 million (22.3%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, total operating expenses increased $334.3 million (10.5%). Included in this increase are special charges of $13.8 million related to Lakewood Hospital and the transition of healthcare services in the City of Lakewood,

Ohio, and a $35.8 million increase in costs related to a specialty pharmacy. In 2015 the System implemented salary adjustments to caregivers in nursing and other clinical institutes. The System also experienced an increase in purchased service expenses and consulting expenses related to certain strategic projects and initiatives. Despite the growth in expenses caused by increased patient volumes and inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System experienced solid cost management primarily through implementation of Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. Management continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries and benefits increased $378.7 million (20.5%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, salaries and benefits increased $179.2 million (9.7%). Same facility salaries, excluding benefits, increased $159.3 million (10.2%) due to annual salary adjustments averaging 1-2% across the System that were awarded in the second quarter of 2016 and a 4.3% increase in average full-time equivalent employees in the first six months of 2016 compared to the same period in 2015. The System has also invested in its caregivers in 2015 by increasing the minimum wage across the System, increasing the starting salary for nurses and providing salary adjustments to current caregivers in nursing and other clinical institutes. Same facility employee benefit costs increased $19.8 million (7.0%). The System experienced an $18.1 million increase in retirement benefit expenses and a $10.0 million increase in FICA expenses. These increases were offset by a $5.8 million decrease in employee and retiree health care costs.

Supplies expense increased $49.6 million (15.5%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, supplies expense increased $14.8 million (4.6%). The System experienced a $14.6 million increase in same facility implantables and other medical supplies and a $0.2 million increase in same facility non-medical supplies. To address the challenge of rising supply and service costs in the healthcare industry, management is engaged in an organizational transformation program to identify and implement clinical and non-clinical savings initiatives through renegotiation, product standardization, utilization changes and improvements in procurement to payment processes.

Pharmaceutical costs increased $98.3 million (31.0%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, pharmaceutical costs increased $71.8 million (22.6%). The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $35.8 million in the first six months of 2016 compared to the same period in 2015. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $62.9 million (34.7%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, purchased services and other fees increased $24.2 million (13.4%). The increase in same facility purchased service expenses was primarily due to increased costs

related to certain System projects, including the EAPM implementation at the Clinic's main campus and family health centers and new technology for the Human Resources Department.

Administrative services increased $24.8 million (36.9%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, administrative services increased $16.6 million (24.6%). The increase in same facility administrative services was primarily due to an increase in consulting fees and other professional services of $12.0 million related to certain strategic initiatives of the System, an increase in travel and professional education expenses of $3.6 million and an increase in expenses related to research activities of $1.0 million.

Facilities expense increased $35.6 million (25.7%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, facilities expense increased $10.0 million (7.2%). The increase in same facility facilities expense was primarily due to an increase in repairs and maintenance costs across the System.

Insurance expense increased $5.3 million (15.1%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, insurance expense increased $0.9 million (2.6%). The increase in same facility insurance expense was primarily due to an increase in professional malpractice expense. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense increased $3.4 million (5.5%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, interest expense decreased $0.4 million (0.7%). The System made $86.8 million of principal payments on bonds, notes and capital leases in 2016, which reduced the amount of interest due on outstanding debt. This was partially offset by interest incurred on the Series 2014A CP Notes and a $60 million draw on a line of credit, which occurred in January 2016.

Depreciation and amortization expenses increased $29.9 million (14.7%) in the first six months of 2016 compared to the same period in 2015. On a same facility basis, depreciation and amortization expenses increased $3.4 million (1.7%). Changes in depreciation include property, plant and equipment that was fully depreciated in 2015, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2016.

The System incurred and recorded $19.2 million of special charges in the first six months of 2016. Special charges in the first six months of 2016 are comprised of $5.4 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place and $13.8 million related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a detailed description of the terms of the agreement, refer to "LAKEWOOD

HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $62.1 million in the first six months of 2016 compared to a gain of $159.3 million in 2015. Investment returns were unfavorable by $26.9 million in the first six months of 2016 compared to the same period in 2015. The System's long-term investment portfolio reported investment gains of 1.5% for the first six months of 2016, which is lower than the portfolio's benchmark gain of 3.4% and lower than investment gains of 2.5% experienced in the first six months of 2015. Derivative losses were unfavorable by $64.7 million in the first six months of 2016 compared to the same period in 2015. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements.

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

Patient accounts receivable, net of allowances for uncollectible accounts, increased $106.2 million (11.2%) from December 31, 2015 to June 30, 2016. The increase in patient receivables is partially due to the increase in net patient service revenue resulting from rate increases on the System's managed care contracts that became effective in January 2016. Additionally, the System has experienced a growth in patient responsibility accounts receivable. Patient responsibility accounts, which represents the portion of services that is not paid by a patient's insurance company, have increased as a result of employers shifting a greater portion of the cost of care to employees, typically in the form of co-pays and deductibles. These balances have continued to grow and are generally more difficult to collect than traditional insurance payors. Patient responsibility accounts receivable also tends to be seasonally higher in the first half of the year as many insurance plans have annual deductible requirements. The System records estimated allowances that result in patient accounts receivable being reported at the net amount expected to be received. Days revenue outstanding for the System increased from 47 days at December 31, 2015 to 55 days at June 30, 2016.

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

Other current assets decreased $41.7 million (10.2%) from December 31, 2015 to June 30, 2016. The decrease in other current assets was primarily due to a $45.2 million decrease in receivables related to the timing of receipts for various Medicare and Medicaid programs, a $8.9 million decrease in electronic health record

incentive program receivables due to the timing of payments for this program, collection of a $7.3 million miscellaneous receivable that was accrued in 2015 and a $3.5 million decrease in the current portion of pledges receivable. These decreases were offset by a $17.2 million increase in prepaid expenses primarily related to annual maintenance contracts and a $9.3 million increase in inventories.

Unrestricted investments decreased $94.9 million (1.5%) from December 31, 2015 to June 30, 2016. The System experienced $359.1 million of positive cash flow from operations and investment income in the first six months of 2016. The positive operating cash flow was offset by net capital expenditures of $304.0 million, principal payment on long-term debt of $86.8 million and a transfer to funds held by trustees of $39.8 million for additional collateral posted with the counterparties on the System's derivative contracts.

Funds held by trustees increased $51.0 million (40.6%) from December 31, 2015 to June 30, 2016. The increase in funds held by trustee is primarily due to a $39.8 million increase in collateral posted with the counterparties on the System's derivative contracts, $11.7 million of remaining project funds from the issuance of the Series 2014 CP Notes and $3.5 million of additional collateral to support a futures and options program within the System's investment portfolio. These increases were offset by a $4.0 million reduction in a debt service reserve fund related to Akron General bonds. The debt service reserve fund was returned to the System in the first quarter of 2016 when the related Akron bonds were defeased.

Assets held for self-insurance increased $19.4 million (20.7%) from December 31, 2015 to June 30, 2016. The increase in self-insurance assets is primarily due to insurance premiums received by the captive in excess of reimbursement payments for claims previously settled and paid by other System entities and investment gains experienced in the System's captive insurance subsidiary.

Donor restricted assets increased $18.3 million (3.2%) from December 31, 2015 to June 30, 2016. The increase in donor restricted assets was primarily from the receipt of donor restricted gifts in excess of expenditures from restricted funds and investment gains on restricted investments.

Net property, plant and equipment increased $25.2 million (0.6%) from December 31, 2015 to June 30, 2016. The System had net expenditures for property, plant and equipment of $304.0 million, offset by depreciation expense of $243.0 million, which includes $11.6 million of accelerated depreciation expense recorded in special charges. Capital expenditures in 2016 include amounts paid on retainage liabilities recorded at December 31, 2015 and exclude assets acquired through capital lease arrangements. Retainage liabilities decreased $44.4 million and new capital leases totaled $7.7 million in the first six months of 2016. Expenditures for property, plant and equipment were incurred at numerous facilities across the System and include expenditures for strategic construction, expansion and technological investment as well as replacement of existing facilities and equipment. For a complete description of many of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets increased $20.8 million (3.6%) from December 31, 2015 to June 30, 2016. The increase in noncurrent assets was primarily due to a $20.5 increase in a note receivable related to construction financing of a hotel on the Clinic's main campus.

Accounts payable decreased $38.2 million (9.3%) from December 31, 2015 to June 30, 2016. The decrease in accounts payable was primarily attributable to a $44.4 million decrease in retainage liabilities associated with the System's construction projects offset by an $8.7 million increase in outstanding checks. Other changes relate to the timing of payment processing for trade payables.

Compensation and amounts withheld from payroll increased $61.8 million (20.9%) from December 31, 2015 to June 30, 2016. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Short-term borrowings increased $60.0 million (100.0%) from December 31, 2015 to June 30, 2016. In January 2016, the System entered into a line of credit with a financial institution totaling $60.0 million and drew the full amount. A portion of the proceeds from the draw on the line of credit, together with the issuance of the Series 2014A CP Notes, were used to defease the Series 2012 Akron Bonds and redeem the Series 2012 taxable Akron Bonds, the Series 2014A Akron Bonds and the Series 2014B Akron Bonds.

Current portion of long-term debt increased $79.5 million (83.1%) from December 31, 2015 to June 30, 2016. The increase in the current portion of long-term debt was comprised of a $97.8 million increase related to bond payments and an $18.2 million decrease related to notes payable and capital leases. The increase in the current portion of bond payments primarily relates to the issuance of the Series 2014 CP Notes for $100 million. The decrease in notes payable and capital leases primarily relate to payments on notes and leases that matured in 2016. The System also reclassified debt from long-term to current, offset by regularly scheduled principal payments.

Variable rate debt classified as current decreased $61.0 million (11.7%) from December 31, 2015 to June 30, 2016. Long-term debt classified as current consists of variable-rate bonds supported by the System's self-liquidity program and bonds with letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds. The reduction in the variable rate debt classified as current in the first six months of 2016 is primarily due an $86.0 million decrease related to the redemption of the Series 2014A Akron Bonds and the Series 2014B Akron Bonds offset by a $25.1 million increase.

Other current liabilities decreased $25.0 million (5.4%) from December 31, 2015 to June 30, 2016. The decrease in other current liabilities is primarily due to a $37.0 million decrease in state franchise fee liabilities due to the timing of the payments for this program and a $14.2 million decrease in current third-party liabilities. These decreases were offset by a $14.5 million increase in deferred revenue related to international management contracts.

Hospital revenue bonds decreased $140.7 million (5.2%) from December 31, 2015 to June 30, 2016. The decrease in hospital revenue bonds is primarily due to the reclassification of $56.4 million from long-term to current for bond payments due within one year, the reclassification of $25.1 million from long-term to variable rate debt classified as current and the defeasance and redemption of $56.5 million of Akron General bonds that were classified as long-term at December 31, 2015.

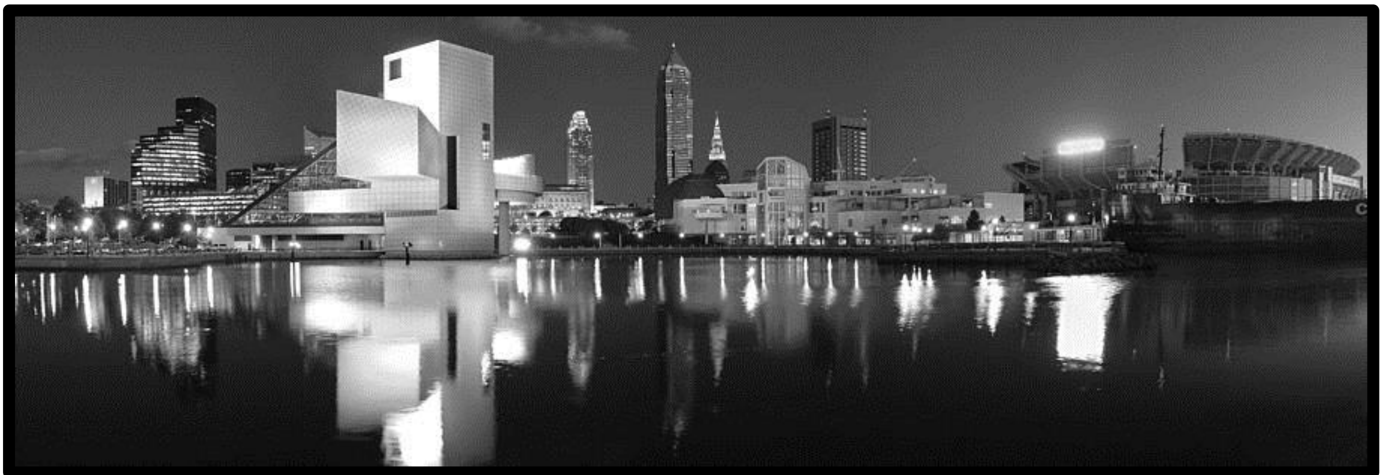
Notes payable and capital leases decreased $2.0 million (0.4%) from December 31, 2015 to June 30, 2016. The decrease is primarily due to regularly scheduled principal payments on notes

payable and capital leases, offset by $7.7 million of new capital leases.

Professional and general insurance liability reserves increased $16.8 million (12.1%) from December 31, 2015 to June 30, 2016. The increase is due to the growth in expected claim liabilities in excess of claim liability payments.

Other noncurrent liabilities increased $59.0 million (12.3%) from December 31, 2015 to June 30, 2016. The increase in other noncurrent liabilities is primarily due to a $52.5 million increase in derivative liabilities associated with changes in the fair value of the System's interest rate swap and foreign currency exchange derivative contracts. The System entered into five foreign currency contract agreements in the second quarter of 2016. The fair value of the foreign currency contracts at June 30, 2016 was a liability of $9.8 million.

Total net assets increased $121.6 million (1.6%) from December 31, 2015 to June 30, 2016. Unrestricted net assets increased $111.1 million (1.7%) primarily due to an excess of revenues over expenses of $109.8 million. Temporarily restricted net assets increased $7.3 million (1.2%), primarily due to $25.0 million in temporarily restricted gifts and $7.2 million in net investment income offset by $22.9 million in assets released from restrictions. Permanently restricted net assets increased $3.2 million (1.1%) primarily due to $6.1 million of permanently restricted gifts offset by a $2.9 million decrease in the value of perpetual trusts.



Cleveland Skyline
Cleveland, Ohio

FORWARD-LOOKING STATEMENTS

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

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

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