Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended March 31, 2018

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	March 31 2018	December 31 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 209,162	$ 241,227
Patient receivables, net	1,069,781	1,012,903
Investments for current use	51,051	154,971
Other current assets	372,170	374,726
Total current assets	1,702,164	1,783,827
Investments:		
Long-term investments	7,797,858	7,729,697
Funds held by trustees	48,211	69,234
Assets held for self-insurance	113,300	159,802
Donor restricted assets	725,685	717,410
	8,685,054	8,676,143
Property, plant, and equipment, net	4,716,820	4,699,697
Other assets:		
Pledges receivable, net	156,978	151,019
Trusts and interests in foundations	81,205	80,643
Other noncurrent assets	474,106	475,010
	712,289	706,672
Total assets	$ 15,816,327	$ 15,866,339

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	March 31 2018	December 31 2017
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 412,715	$ 503,691
Compensation and amounts withheld from payroll	376,115	345,446
Current portion of long-term debt	460,277	457,813
Variable rate debt classified as current	573,270	573,270
Other current liabilities	418,882	438,662
Total current liabilities	2,241,259	2,318,882
Long-term debt:		
Hospital revenue bonds	2,797,993	2,861,438
Notes payable and capital leases	130,644	134,840
	2,928,637	2,996,278
Other liabilities:		
Professional and general insurance liability reserves	139,469	147,327
Accrued retirement benefits	488,606	492,833
Other noncurrent liabilities	543,519	567,566
	1,171,594	1,207,726
Total liabilities	6,341,490	6,522,886
Net assets:		
Unrestricted	8,466,053	8,346,649
Temporarily restricted	670,775	662,189
Permanently restricted	338,009	334,615
Total net assets	9,474,837	9,343,453
Total liabilities and net assets	$ 15,816,327	$ 15,866,339

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended March 31	
	2018	2017
Unrestricted revenues		
Net patient service revenue before provision for uncollectible accounts		$ 1,958,379
Provision for uncollectible accounts		(89,096)
Net patient service revenue	$ 1,909,774	1,869,283
Other	212,677	199,620
Total unrestricted revenues	2,122,451	2,068,903
Expenses		
Salaries, wages, and benefits	1,183,220	1,157,237
Supplies	203,199	193,625
Pharmaceuticals	254,225	223,665
Purchased services and other fees	128,260	126,126
Administrative services	39,977	44,051
Facilities	85,230	83,377
Insurance	19,874	20,149
	1,913,985	1,848,230
Operating income before interest, depreciation, and amortization expenses	208,466	220,673
Interest	33,001	36,173
Depreciation and amortization	127,055	121,829
Operating income before special charges	48,410	62,671
Special charges	834	1,958
Operating income	47,576	60,713
Nonoperating gains and losses		
Investment return	37,104	242,682
Derivative gains	15,416	2,056
Other, net	6,376	3,112
Net nonoperating gains and losses	58,896	247,850
Excess of revenues over expenses	106,472	308,563

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at January 1, 2017	$7,088,209	$ 627,426	$ 310,164	$ 8,025,799
Excess of revenues over expenses	308,563	-	-	308,563
Donated capital and assets released from restrictions for capital purposes	907	(907)	-	-
Gifts and bequests	-	23,497	4,106	27,603
Net investment income	-	14,402	-	14,402
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(7,894)	-	(7,894)
Retirement benefits adjustment	(658)	-	-	(658)
Change in value of perpetual trusts	-	-	545	545
Foreign currency translation	3,673	-	-	3,673
Net change in unrealized losses on nontrading investments	(833)	-	-	(833)
Other	77	-	-	77
Increase in net assets	311,729	29,098	4,651	345,478
Balances at March 31, 2017	$7,399,938	$ 656,524	$ 314,815	$ 8,371,277
Balances at January 1, 2018	$8,346,649	$ 662,189	$ 334,615	$ 9,343,453
Excess of revenues over expenses	106,472	-	-	106,472
Donated capital and assets released from restrictions for capital purposes	597	(597)	-	-
Gifts and bequests	-	22,445	2,764	25,209
Transfer of net assets	11	(11)	-	-
Net investment income	-	200	-	200
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(13,451)	-	(13,451)
Retirement benefits adjustment	(715)	-	-	(715)
Change in value of perpetual trusts	-	-	630	630
Foreign currency translation	13,000	-	-	13,000
Other	39	-	-	39
Increase in net assets	119,404	8,586	3,394	131,384
Balances at March 31, 2018	$8,466,053	$ 670,775	$ 338,009	$ 9,474,837

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31	
	2018	2017
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 131,384	$ 345,478
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Retirement benefits adjustment	715	658
Net realized and unrealized gains on investments	(27,320)	(248,797)
Depreciation and amortization	127,852	121,829
Provision for uncollectible accounts	-	89,096
Foreign currency translation gain	(13,000)	(3,673)
Restricted gifts, bequests, investment income, and other	(26,039)	(42,550)
Accreted interest and amortization of bond premiums	(1,545)	(377)
Net gain in value of derivatives	(19,843)	(11,143)
Changes in operating assets and liabilities:		
Patient receivables	(56,878)	(106,589)
Other current assets	21	(35,655)
Other noncurrent assets	710	(915)
Accounts payable and other current liabilities	(49,545)	(72,764)
Other liabilities	(17,004)	(3,679)
Net cash provided by operating activities and net nonoperating gains and losses	49,508	30,919
Financing activities		
Principal payments on long-term debt	(66,998)	(61,390)
Change in pledges receivables, trusts and interests in foundations	(3,986)	(6,896)
Restricted gifts, bequests, investment income, and other	26,039	42,550
Net cash used in financing activities	(44,945)	(25,736)
Investing activities		
Expenditures for property and equipment, net	(158,554)	(119,124)
Net change in cash equivalents reported in long-term investments	74,796	(35,178)
Purchases of investments	(432,419)	(439,490)
Sales of investments	479,952	410,244
Net cash used in investing activities	(36,225)	(183,548)
Effect of exchange rate changes on cash	(403)	284
Decrease in cash and cash equivalents	(32,065)	(178,081)
Cash and cash equivalents at beginning of year	241,227	520,628
Cash and cash equivalents at end of period	$ 209,162	$ 342,547

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

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

2. Organization and Consolidation

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

The System is the leading provider of healthcare services in northeast Ohio. As of March 31, 2018, the System operates 13 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 21 outpatient Family Health Centers, 10 ambulatory surgery centers, as well as numerous physician offices located throughout a seven-county area of northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada, and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, and Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that is part of Mubadala Development Company's network of healthcare facilities located in Abu Dhabi, United Arab Emirates with approximately 364 staffed beds.

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

3. Accounting Policies

Recent Accounting Pronouncements

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

3. Accounting Policies (continued)

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

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

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements for Not-for-Profit Entities*. This standard intends to make certain improvements to the current reporting requirements for not-for-profit entities. This standard sets forth changes to net asset classification requirements and the information presented about a not-for-profit entity's liquidity, financial performance and cash flows. ASU 2016-14 is effective for the System for annual reporting periods beginning after December 15, 2017, and interim periods beginning after December 15, 2018. The System is currently evaluating the impact that ASU 2016-14 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

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

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

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

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

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

5. Net Patient Service Revenue (continued)

The System has agreements with third-party payors that generally provide for payments to the System at amounts different from its established rates. For uninsured patients who do not qualify for charity care, the System recognizes revenue based on established rates, subject to certain discounts and implicit price concessions as determined by the System. The System determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the System's policy, and implicit price concessions provided to uninsured patients. Implicit price concessions represent differences between amounts billed and the estimated consideration the System expects to receive from patients, which are determined based on historical collection experience, current market conditions and other factors. The System determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies, and historical experience.

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

The System is paid a prospectively determined rate for the majority of inpatient acute care and outpatient, skilled nursing, and rehabilitation services provided (principally Medicare, Medicaid, and certain insurers). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Payments for capital are received on a prospective basis for Medicare and on a cost reimbursement methodology for Medicaid. Payments are received on a prospective basis for the System's medical education costs, subject to certain limits. The System is paid for cost reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports by the System and audits thereof by the Medicare Administrative Contractor.

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

5. Net Patient Service Revenue (continued)

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

The System provides care to patients who do not have the ability to pay and who qualify for charity care pursuant to established policies of the System. Charity care is defined as services for which patients have the obligation and willingness to pay but do not have the ability to do so. The System does not report charity care as net patient service revenue.

Net patient service revenue by major payor source for the three months ended March 31, 2018 and 2017, are as follows (in thousands):

	2018		**2017**	
Medicare	**$ 704,336**	**37%**	$ 664,007	36%
Medicaid	**159,391**	**8**	160,774	9
Managed care and commercial	**1,039,019**	**55**	1,037,076	55
Self-pay	**7,028**	**–**	7,426	–
	$ 1,909,774	**100%**	$ 1,869,283	100%

5. Net Patient Service Revenue (continued)

As a result of certain changes required by ASU 2014-09, the majority of the System's provision for uncollectible accounts are recorded as a direct reduction to net patient service revenue instead of being presented as a separate line item on the consolidated statements of operations and changes in net assets. The adoption of ASU 2014-09 has no impact on the System's accounts receivable as it was historically recorded net of allowance for uncollectible accounts and contractual adjustments on the consolidated balance sheets. The impact of adopting ASU 2014-09 on the consolidated statements of operations and changes in net assets for the three months ended March 31, 2018 was as follows (in thousands):

	Three months ended March 31, 2018	
	As Reported	Prior to adopting ASU 2014-09
Net patient service revenue before provision for uncollectible accounts		$ 1,984,083
Provision for uncollectible accounts		(74,309)
Net patient service revenue	$ 1,909,774	$ 1,909,774

6. Fair Value Measurements

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

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

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

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

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

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

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

6. Fair Value Measurements (continued)

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

March 31, 2018	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 663,661	$ 132	$ –	$ 663,793
Fixed income securities:				
U.S. treasuries	1,059,683	–	–	1,059,683
U.S. government agencies	–	20,128	–	20,128
U.S. corporate	–	60,826	–	60,826
U.S. government agencies asset-backed securities	–	25,882	–	25,882
Corporate asset-backed securities	–	5,312	–	5,312
Foreign	–	17,453	–	17,453
Fixed income mutual funds	387,791	–	–	387,791
Common and preferred stocks:				
U.S.	473,967	1,675	–	475,642
Foreign	321,084	1,418	–	322,502
Equity mutual funds	241,109	–	–	241,109
Total cash and investments	3,147,295	132,826	–	3,280,121
Perpetual and charitable trusts	–	54,290	–	54,290
Total assets at fair value	$ 3,147,295	$ 187,116	$ –	$ 3,334,411
Liabilities				
Interest rate swaps	$ –	$ 104,146	$ –	$ 104,146
Total liabilities at fair value	$ –	$ 104,146	$ –	$ 104,146

6. Fair Value Measurements (continued)

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

6. Fair Value Measurements (continued)

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

	March 31 2018	December 31 2017
Cash, cash equivalents, and investments measured at fair value	**$ 3,280,121**	$ 3,427,464
Commingled funds measured at net asset value	**2,954,842**	2,948,317
Alternative investments accounted for under the equity method	**2,689,104**	2,481,560
Pending purchases of investments	**21,200**	215,000
Total cash, cash equivalents, and investments	**$ 8,945,267**	$ 9,072,341
Perpetual and charitable trusts measured at fair value	**$ 54,290**	$ 53,728
Interests in foundations	**26,915**	26,915
Trusts and interests in foundations	**$ 81,205**	$ 80,643

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 2.5% to 5.0%, which are based on Treasury yield curve interest rates or the assumed yield of the trust assets. The fair value of charitable trusts in which the System is a remainder beneficiary is based on the System's beneficial interest in the investments held in the trust, which are measured at fair value.

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

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

The System's objective with respect to interest rate risk is to manage the risk of rising interest rates on the System's variable rate debt and certain variable rate operating lease payments. Consistent with its interest rate risk management objective, the System entered into various interest rate swap agreements with a total outstanding notional amount of $603.6 million and $615.0 million at March 31, 2018 and December 31, 2017, respectively. During the term of these transactions, the System pays interest at a fixed rate and receives interest at a variable rate based on the London Interbank Offered Rate (LIBOR) or the Securities Industry and Financial Markets Association Index (SIFMA). The swap agreements are not designated as hedging instruments. Net interest paid or received under the swap agreements is included in derivative losses in the consolidated statements of operations and changes in net assets.

7. Derivative Instruments (continued)

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

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at March 31 2018	Notional Amount at December 31 2017
Fixed	2021	3.21%	68% of LIBOR	**$ 30,145**	$ 31,725
Fixed	2024	3.42%	68% of LIBOR	**26,500**	27,200
Fixed	2027	3.56%	68% of LIBOR	**120,113**	124,303
Fixed	2028	5.12%	100% of LIBOR	**36,605**	37,730
Fixed	2028	3.51%	68% of LIBOR	**28,285**	29,125
Fixed	2030	5.07%	100% of LIBOR	**59,075**	59,075
Fixed	2030	5.06%	100% of LIBOR	**59,050**	59,050
Fixed	2031	3.04%	68% of LIBOR	**46,975**	49,850
Fixed	2032	4.32%	79% of LIBOR	**2,258**	2,279
Fixed	2032	4.33%	70% of LIBOR	**4,515**	4,557
Fixed	2032	3.78%	70% of LIBOR	**2,258**	2,279
Fixed	2036	4.90%	100% of LIBOR	**49,700**	49,700
Fixed	2036	4.90%	100% of LIBOR	**76,950**	76,950
Fixed	2037	4.62%	100% of SIFMA	**61,165**	61,165
				$ 603,594	$ 614,988

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

7. Derivative Instruments (continued)

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

	Derivatives Liability			
	March 31, 2018		December 31, 2017	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 104,146**	Other noncurrent liabilities	$ 123,989

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

	Location of Gain Recognized	Quarter Ended March 31 2018	2017
Derivatives not designated as hedging instruments			
Interest rate swap agreements	Derivative gains	**$ 15,416**	$ 1,215
Foreign currency contracts	Derivative gains	**$ -**	$ 841

The System has used various derivative contracts in connection with certain prior obligations and investments. Although minimum credit ratings are required for counterparties, this does not eliminate the risk that a counterparty may fail to honor its obligations. Derivative contracts are subject to periodic "mark-to-market" valuations. A derivative contract may, at any time, have a positive or negative value to the System. In the event that the negative value reaches certain thresholds established in the derivative contracts, the System is required to post collateral, which could adversely affect its liquidity. At March 31, 2018 and December 31, 2017, the System posted $48.1 million and $69.2 million, respectively, of collateral with counterparties that is included in funds held by trustees in the consolidated balance sheets. In addition, if the System were to choose to terminate a derivative contract or if a derivative contract were terminated pursuant to an event of default or a termination event as described in the derivative contract, the System could be required to pay a termination payment to the counterparty.

8. Pensions and Other Postretirement Benefits

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

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

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

	Quarter Ended March 31	
	2018	**2017**
Amounts related to defined benefit pension plans:		
Service cost	**$ (378)**	**$ 49**
Interest cost	**16,178**	**17,836**
Expected return on assets	**(18,697)**	**(21,167)**
Net amortization and deferral	**(478)**	**(420)**
Total defined benefit pension plans	**(3,375)**	**(3,702)**
Defined contribution plans	**64,696**	**61,279**
	$ 61,321	**$ 57,577**

8. Pensions and Other Postretirement Benefits (continued)

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

As of March 31, 2018, the System has made contributions of $1.9 million to the defined benefit pension plans. The System expects to make additional contributions of $5.8 million to the defined benefit pension plans for the remainder of 2018.

9. Special Charges

The System incurred and recorded special charges of $0.8 million and $1.9 million in the first three months of 2018 and 2017, respectively, representing accelerated depreciation expense and other property, plant and equipment costs related to Lakewood Hospital Association (LHA). The Foundation, LHA and the City of Lakewood entered into an agreement in December 2015 that outlines the transition of healthcare services in the City of Lakewood. Participation in the agreement by the City of Lakewood was authorized by an ordinance adopted by Lakewood City Council. Under the terms of the agreement, the Foundation and LHA will make contributions over the next 16 years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Foundation will construct, own and operate an approximately 62,000-square-foot family health center expected to open in 2018 that will be located adjacent to the site of the former hospital. LHA ceased inpatient operations at the hospital in February 2016, while the current emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The cessation of inpatient services at the hospital is not considered a discontinued operation since the System provides inpatient hospital services at the Foundation and its subsidiary hospitals in the Northeast Ohio area.

10. Subsequent Events

The System evaluated events and transactions occurring subsequent to March 31, 2018 through May 30, 2018, the date the consolidated financial statements were issued. During this period, there were no subsequent events requiring recognition in the consolidated financial statements, and there were no nonrecognized subsequent events requiring disclosure, except that on April 1, 2018 the Foundation through a subsidiary became the sole member of The Union Hospital Association through a non-cash business combination transaction. The Union Hospital Association operates a 100-bed hospital and several off-campus satellite services in Tuscarawas County and surrounding counties in Eastern Ohio.

Unaudited Consolidating Balance Sheets

($ in thousands)

	March 31, 2018				December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ -	$ 209,162	$ -	$ 209,162	$ 27,644	$ 213,583	$ -	$ 241,227
Patient receivables, net	957,427	143,661	(31,307)	1,069,781	904,105	142,450	(33,652)	1,012,903
Due from affiliates	29,511	61,018	(90,529)	-	55,942	50	(55,992)	-
Investments for current use	-	51,051	-	51,051	103,920	51,051	-	154,971
Other current assets	315,985	60,188	(4,003)	372,170	310,960	64,134	(368)	374,726
Total current assets	1,302,923	525,080	(125,839)	1,702,164	1,402,571	471,268	(90,012)	1,783,827
Investments:								
Long-term investments	7,346,724	451,134	-	7,797,858	7,289,000	440,697	-	7,729,697
Funds held by trustees	48,211	-	-	48,211	69,234	0	-	69,234
Assets held for self-insurance	-	113,300	-	113,300	-	159,802	-	159,802
Donor restricted assets	693,462	32,223	-	725,685	685,292	32,118	-	717,410
	8,088,397	596,657	-	8,685,054	8,043,526	632,617	-	8,676,143
Property, plant, and equipment, net	3,826,235	890,585	-	4,716,820	3,819,800	879,897	-	4,699,697
Other assets:								
Pledges receivable, net	156,646	332	-	156,978	150,690	329	-	151,019
Trusts and beneficial interests in foundations	72,281	8,924	-	81,205	71,866	8,777	-	80,643
Other noncurrent assets	563,390	62,782	(152,066)	474,106	566,548	60,388	(151,926)	475,010
	792,317	72,038	(152,066)	712,289	789,104	69,494	(151,926)	706,672
Total assets	$ 14,009,872	$ 2,084,360	$ (277,905)	$ 15,816,327	$ 14,055,001	$ 2,053,276	$ (241,938)	$ 15,866,339

	March 31, 2018				December 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable	$ 338,648	$ 74,258	$ (191)	$ 412,715	$ 432,859	$ 71,024	$ (192)	$ 503,691
Compensation and amounts withheld from payroll	336,584	39,531	-	376,115	311,159	34,287	-	345,446
Short-term borrowings	-	-	-	-	0	0	-	-
Current portion of long-term debt	80,016	380,333	(72)	460,277	77,208	380,677	(72)	457,813
Variable rate debt classified as current	514,393	58,877	-	573,270	514,396	58,874	-	573,270
Due to affiliates	14,241	30,646	(44,887)	-	50	55,942	(55,992)	-
Other current liabilities	339,653	113,078	(33,849)	418,882	358,475	116,352	(36,165)	438,662
Total current liabilities	1,623,535	696,723	(78,999)	2,241,259	1,694,147	717,156	(92,421)	2,318,882
Long-term debt:								
Hospital revenue bonds	2,797,993	-	-	2,797,993	2,861,438	0	-	2,861,438
Notes payable and capital leases	107,195	170,981	(147,532)	130,644	110,675	171,562	(147,397)	134,840
	2,905,188	170,981	(147,532)	2,928,637	2,972,113	171,562	(147,397)	2,996,278
Other liabilities:								
Professional and general insurance liability reserves	56,440	83,029	-	139,469	55,875	91,452	-	147,327
Accrued retirement benefits	450,062	38,544	-	488,606	453,710	39,123	-	492,833
Other noncurrent liabilities	504,859	87,914	(49,254)	543,519	526,814	40,752	-	567,566
	1,011,361	209,487	(49,254)	1,171,594	1,036,399	171,327	-	1,207,726
Total liabilities	5,540,084	1,077,191	(275,785)	6,341,490	5,702,659	1,060,045	(239,818)	6,522,886
Net assets:								
Unrestricted	7,503,049	965,124	(2,120)	8,466,053	7,397,798	950,971	(2,120)	8,346,649
Temporarily restricted	647,142	23,633	-	670,775	638,208	23,981	-	662,189
Permanently restricted	319,597	18,412	-	338,009	316,336	18,279	-	334,615
Total net assets	8,469,788	1,007,169	(2,120)	9,474,837	8,352,342	993,231	(2,120)	9,343,453
Total liabilities and net assets	$ 14,009,872	$ 2,084,360	$ (277,905)	$ 15,816,327	$ 14,055,001	$ 2,053,276	$ (241,938)	$ 15,866,339

See notes to unaudited consolidated financial statements.

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

Unaudited Consolidating Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended March 31, 2018				Three Months Ended March 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue before provision for uncollectible accounts					$ 1,787,730	$ 228,030	$ (57,381)	$ 1,958,379
Provision for uncollectible accounts					(74,567)	(14,529)	-	(89,096)
Net patient service revenue	$ 1,763,693	$ 214,010	$ (67,929)	$ 1,909,774	1,713,163	213,501	(57,381)	1,869,283
Other	184,278	65,418	(37,019)	212,677	172,399	70,852	(43,631)	199,620
Total unrestricted revenues	1,947,971	279,428	(104,948)	2,122,451	1,885,562	284,353	(101,012)	2,068,903
Expenses								
Salaries, wages, and benefits	1,112,501	148,873	(78,154)	1,183,220	1,082,371	141,717	(66,851)	1,157,237
Supplies	181,873	21,488	(162)	203,199	169,820	23,940	(135)	193,625
Pharmaceuticals	234,030	20,195	-	254,225	204,110	19,555	-	223,665
Purchased services and other fees	109,475	23,671	(4,886)	128,260	102,562	35,416	(11,852)	126,126
Administrative services	29,757	15,493	(5,273)	39,977	33,846	15,383	(5,178)	44,051
Facilities	68,373	17,612	(755)	85,230	67,282	16,925	(830)	83,377
Insurance	17,281	18,286	(15,693)	19,874	17,348	18,967	(16,166)	20,149
	1,753,290	265,618	(104,923)	1,913,985	1,677,339	271,903	(101,012)	1,848,230
Operating income before interest, depreciation, and amortization expenses	194,681	13,810	(25)	208,466	208,223	12,450	-	220,673
Interest	29,371	3,630	-	33,001	33,635	2,538	-	36,173
Depreciation and amortization	111,259	15,821	(25)	127,055	107,482	14,347	-	121,829
Operating income (loss) before special charges	54,051	(5,641)	-	48,410	67,106	(4,435)	-	62,671
Special charges	-	834	-	834	-	1,958	-	1,958
Operating income (loss)	54,051	(6,475)	-	47,576	67,106	(6,393)	-	60,713
Nonoperating gains and losses								
Investment return	34,199	2,905	-	37,104	224,206	18,476	-	242,682
Derivative gains (losses)	15,940	(524)	-	15,416	2,679	(623)	-	2,056
Other, net	1,594	4,782	-	6,376	2,575	537	-	3,112
Net nonoperating gains and losses	51,733	7,163	-	58,896	229,460	18,390	-	247,850
Excess of revenues over expenses	105,784	688	-	106,472	296,566	11,997	-	308,563

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

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

($ in thousands)

Change in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2017	$ 7,143,389	$ 885,858	$ (3,448)	$ 8,025,799
Excess (deficiency) of revenues over expenses	296,566	11,997	-	308,563
Restricted gifts and bequests	26,801	802	-	27,603
Restricted net investment income	13,432	970	-	14,402
Net assets released from restrictions used for operations included in other unrestricted revenues	(7,213)	(681)	-	(7,894)
Contributions (to) from affiliates	(21,822)	21,822	-	-
Retirement benefits adjustment	(658)	-	-	(658)
Change in restricted net assets related to value of perpetual trusts	411	134	-	545
Foreign currency translation	(21)	3,694	-	3,673
Net change in unrealized losses on nontrading investments	(833)	-	-	(833)
Other	(21)	98	-	77
Increase in total net assets	306,642	38,836	-	345,478
Total net assets at March 31, 2017	$ 7,450,031	$ 924,694	$ (3,448)	$ 8,371,277
Total net assets at January 1, 2018	$ 8,352,342	$ 993,231	$ (2,120)	$ 9,343,453
Excess of revenues over expenses	105,784	688	-	106,472
Restricted gifts and bequests	25,149	60	-	25,209
Restricted net investment income	(265)	465	-	200
Net assets released from restrictions used for operations included in other unrestricted revenues	(12,724)	(727)	-	(13,451)
Transfers (to) from affiliates	(323)	323	-	-
Retirement benefits adjustment	(658)	(57)	-	(715)
Change in restricted net assets related to value of perpetual trusts	483	147	-	630
Foreign currency translation	-	13,000	-	13,000
Other	-	39	-	39
Increase in total net assets	117,446	13,938	-	131,384
Total net assets at March 31, 2018	$ 8,469,788	$ 1,007,169	$ (2,120)	$ 9,474,837

See notes to unaudited consolidated financial statements.

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

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31, 2018				Three Months Ended March 31, 2017			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Operating activities and net nonoperating gains and losses								
Increase in total net assets	$ 117,446	$ 13,938	$ -	$ 131,384	$ 306,642	$ 38,836	$ -	$ 345,478
Adjustments to reconcile increase in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:								
Retirement benefits adjustment	658	57	-	715	658	-	-	658
Net realized and unrealized gains on investments	(24,481)	(2,839)	-	(27,320)	(229,625)	(19,172)	-	(248,797)
Depreciation and amortization	111,259	16,618	(25)	127,852	107,482	14,347	-	121,829
Provision for uncollectible accounts	-	-	-	-	74,567	14,529	-	89,096
Foreign currency translation gain	-	(13,000)	-	(13,000)	21	(3,694)	-	(3,673)
Restricted gifts, bequests, investment income, and other	(25,367)	(672)	-	(26,039)	(40,644)	(1,906)	-	(42,550)
Transfers to (from) affiliates	323	(323)	-	-	21,822	(21,822)	-	-
Accreted interest and amortization of bond premiums	(1,548)	3	-	(1,545)	(380)	3	-	(377)
Net gain in value of derivatives	(19,843)	-	-	(19,843)	(11,143)	-	-	(11,143)
Changes in operating assets and liabilities:								
Patient receivables	(53,322)	(1,211)	(2,345)	(56,878)	(93,479)	(20,241)	7,131	(106,589)
Other current assets	19,046	(57,197)	38,172	21	(52,555)	(66,489)	83,389	(35,655)
Other noncurrent assets	2,970	(2,425)	165	710	(758)	(163)	6	(915)
Accounts payable and other current liabilities	(46,041)	(16,926)	13,422	(49,545)	(63,957)	31,116	(39,923)	(72,764)
Other liabilities	(5,853)	38,103	(49,254)	(17,004)	(1,667)	48,584	(50,596)	(3,679)
Net cash provided by (used in) operating activities and net nonoperating gains and losses	75,247	(25,874)	135	49,508	16,984	13,928	7	30,919
Financing activities								
Proceeds from long-term borrowings	-	135	(135)	-	-	7	(7)	-
Principal payments on long-term debt	(65,938)	(1,060)	-	(66,998)	(60,376)	(1,014)	-	(61,390)
Change in pledges receivable, trusts and interests in foundations	(4,011)	25	-	(3,986)	(6,912)	16	-	(6,896)
Restricted gifts, bequests, investment income, and other	25,367	672	-	26,039	40,644	1,906	-	42,550
Net cash (used in) provided by financing activities	(44,582)	(228)	(135)	(44,945)	(26,644)	915	(7)	(25,736)
Investing activities								
Expenditures for property and equipment	(141,516)	(17,038)	-	(158,554)	(101,102)	(18,022)	-	(119,124)
Net change in cash equivalents reported in long-term investments	43,955	30,841	-	74,796	(52,430)	17,252	-	(35,178)
Purchases of investments	(401,182)	(31,237)	-	(432,419)	(384,594)	(54,896)	-	(439,490)
Sales of investments	440,757	39,195	-	479,952	373,454	36,790	-	410,244
Transfers (to) from affiliates	(323)	323	-	-	(21,822)	21,822	-	-
Net cash (used in) provided by investing activities	(58,309)	22,084	-	(36,225)	(186,494)	2,946	-	(183,548)
Effect of exchange rate changes on cash	-	(403)		(403)	(21)	305		284
(Decrease) increase in cash and cash equivalents	(27,644)	(4,421)	-	(32,065)	(196,175)	18,094	-	(178,081)
Cash and cash equivalents at beginning of year	27,644	213,583	-	241,227	303,102	217,526	-	520,628
Cash and cash equivalents at end of period	$ -	$ 209,162	$ -	$ 209,162	$ 106,927	$ 235,620	$ -	$ 342,547

See notes to unaudited consolidated financial statements.

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

Utilization

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

	Year Ended December 31			YTD March 31	
	2015[2]	2016	2017	2017	2018
Total Staffed Beds[1]	4,034	3,931	3,847	3,930	3,866
Percent Occupancy[1]	67.9%	69.3%	70.7%	72.1%	72.7%
Inpatient Admissions[1]					
Acute	146,990	162,930	169,238	43,067	41,606
Post-acute	11,779	12,424	11,710	3,068	2,628
Total	158,769	175,354	180,948	46,135	44,234
Patient Days[1]					
Acute	782,316	846,170	877,891	222,794	223,358
Post-acute	98,268	103,979	93,961	25,510	19,271
Total	880,584	950,149	971,852	248,304	242,629
Average Length of Stay					
Acute	5.30	5.20	5.16	5.16	5.38
Post-acute	8.30	8.39	8.04	8.43	7.65
Surgical Facility Cases					
Inpatient	56,311	59,802	61,529	15,547	15,660
Outpatient	137,139	147,855	145,825	37,453	36,601
Total	193,450	207,657	207,354	53,000	52,261
Emergency Room Visits	542,768	652,073	644,575	161,138	160,286
Outpatient Observations	49,237	58,384	59,894	15,651	15,129
Outpatient Evaluation and Management Visits	3,742,901	4,235,729	4,403,635	1,131,271	1,131,041
Acute Medicare Case Mix Index - Health System	1.91	1.93	1.91	1.90	1.97
Acute Medicare Case Mix Index - Cleveland Clinic	2.47	2.53	2.59	2.58	2.74
Total Acute Patient Case Mix Index - Health System	1.81	1.84	1.85	1.83	1.92
Total Acute Patient Case Mix Index - Cleveland Clinic	2.36	2.45	2.52	2.48	2.64

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

(2) Includes Akron General statistics for November and December 2015. The Clinic became the sole member of Akron General on November 1, 2015.

Utilization (continued)

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

	Year Ended December 31			YTD March 31	
	2015	2016	2017	2017	2018
Total Staffed Beds[(1)]	3,352	3,412	3,352	3,398	3,371
Percent Occupancy[(1)]	69.6%	69.6%	70.8%	72.6%	73.5%
Inpatient Admissions[(1)]					
Acute	138,287	139,300	145,479	37,001	35,963
Post-acute	9,740	9,471	8,980	2,485	2,121
Total	148,027	148,771	154,459	39,486	38,084
Patient Days[(1)]					
Acute	747,231	744,296	767,003	194,461	196,709
Post-acute	73,473	76,113	70,567	20,900	15,932
Total	820,704	820,409	837,570	215,361	212,641
Surgical Facility Cases					
Inpatient	53,839	54,072	56,030	14,068	14,167
Outpatient	132,800	135,918	133,893	34,193	33,003
Total	186,639	189,990	189,923	48,261	47,170
Emergency Room Visits	493,930	535,478	530,316	133,328	133,043
Outpatient Observations	45,687	50,671	52,506	13,783	13,368
Outpatient Evaluation and Management Visits	3,742,901	4,232,729	4,399,738	1,130,273	1,130,133
Acute Medicare Case Mix Index	1.86	1.91	1.90	1.89	1.96
Total Acute Patient Case Mix Index	1.76	1.83	1.84	1.82	1.90

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

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

Payor Mix

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

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

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

OBLIGATED GROUP
Based on Gross Patient Service Revenue

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

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

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

Research Support

($ in thousands)

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

	Year Ended December 31			YTD March 31	
	2015	**2016**	**2017**	**2017**	**2018**
External Grants Earned					
Federal Sources	$103,022	$108,253	$114,942	$28,999	$29,035
Non-Federal Sources	81,796	87,883	92,564	21,317	28,060
Total	184,818	196,136	207,506	50,316	57,095
Internal Support	63,240	59,326	59,873	14,977	10,897
Total Sources of Support	$248,058	$255,462	$267,379	$65,293	$67,992

Key Ratios

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

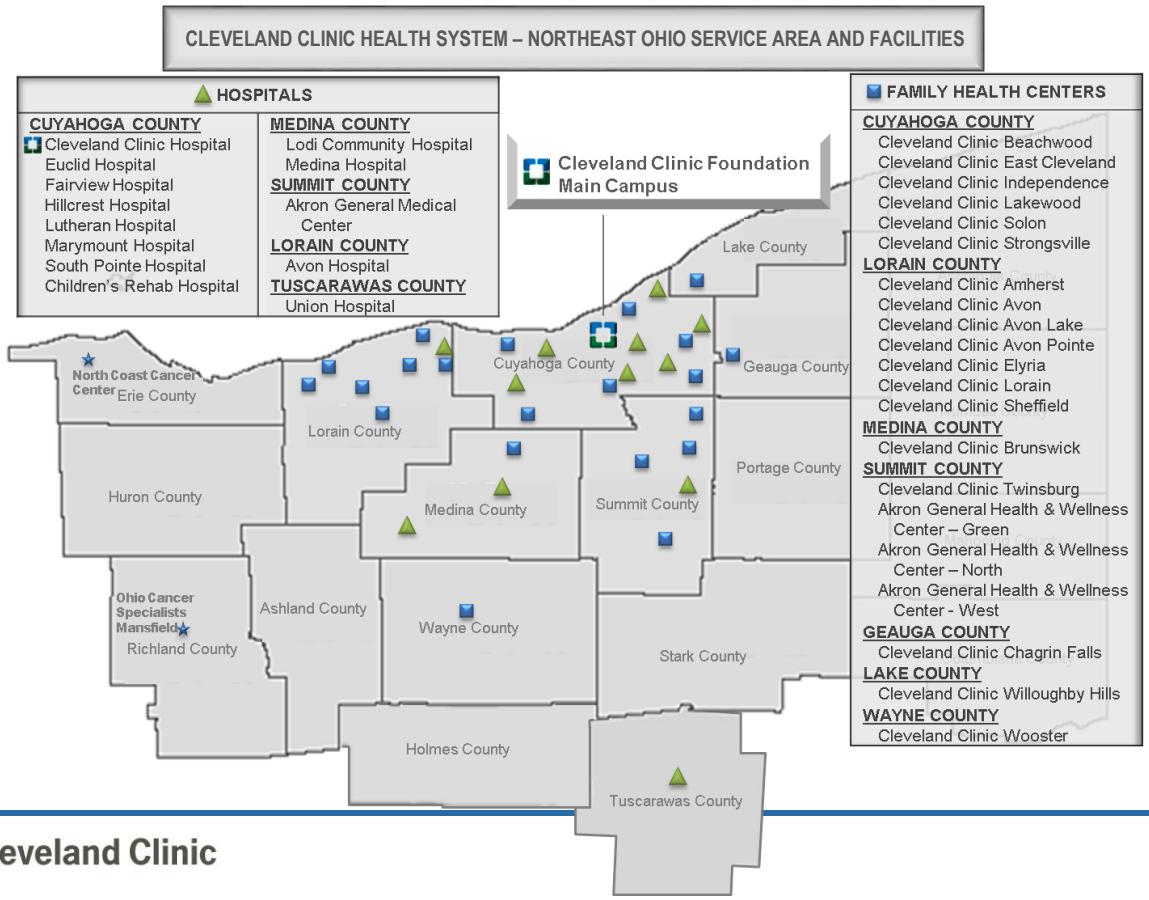
	Year Ended December 31			YTD March 31	
	2015	2016	2017	2017	2018
Liquidity ratios					
Days of cash on hand	347	349	383	351	382
Days of revenue in accounts receivable	47	51	49	52	50
Coverage ratios					
Cash to debt (%)	168.9	172.7	197.9	177.5	202.1
Maximum annual debt service coverage (x)	5.7	3.8	5.3	4.4	5.4
Interest expense coverage (x)	10.1	7.5	9.1	8.3	9.6
Debt to cash flow (x)	3.4	4.6	3.5	3.9	3.4
Leverage ratio					
Debt to capitalization (%)	36.5	36.4	32.5	35.1	31.9
Profitability ratios					
Operating margin (%)	6.7	3.0	3.9	2.9	2.2
Operating cash flow margin (%)	14.7	11.0	11.5	10.7	9.8
Excess margin (%)	8.5	6.2	12.5	13.3	4.9
Return on assets (%)	4.5	3.6	7.3	8.4	2.7

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

OVERVIEW

The Cleveland Clinic Health System (System) is a world-renowned provider of healthcare services and attracted patients from across the United States and from 135 other countries in 2017. As of March 31, 2018, the System operates 13 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 21 outpatient Family Health Centers and 10 ambulatory surgery centers, as well as numerous physician offices, which are located throughout a seven-county area of northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, and Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that is part of Mubadala Development Company's network of healthcare facilities located in Abu Dhabi, United Arab Emirates with approximately 364 staffed beds.

Effective April 1, 2018, the Clinic though a subsidiary became the sole member of The Union Hospital Association through a non-cash business combination transaction. The Union Hospital Association operates a 100-bed hospital and several off-campus satellite services in Tuscarawas County and surrounding counties in Eastern Ohio. For a description of The Union Hospital Association, refer to "UNION HOSPITAL."



The following table sets forth the hospitals operated by the obligated issuers and their affiliates, together with each hospital's staffed bed count as of March 31, 2018:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,294
Avon Hospital	126
Euclid Hospital	165
Fairview Hospital	460
Hillcrest Hospital	440
Lutheran Hospital	194
Marymount Hospital	277
Medina Hospital	121
South Pointe Hospital	139
Weston Hospital	155
	3,371
NON-OBLIGATED	
Akron General Medical Center	450
Children's Rehab Hospital	25
Lodi Hospital	20
	495
HEALTH SYSTEM	3,866

AWARDS & RECOGNITION

The Clinic was ranked as the second best hospital in the United States by *U.S. News and World Report* in its 2017-2018 edition of "America's Best Hospitals." This is the nineteenth consecutive year the Clinic was ranked among the top five hospitals in the United States. The Clinic's Heart and Vascular Institute, located on the Clinic's main campus, was recognized as the best cardiology and heart surgery program in the United States, an honor the Clinic has received annually for twenty-three consecutive years. The Clinic has additionally received the honor of being recognized with the best urology program in the United States. This program was ranked second in the United States last year. The Clinic was nationally ranked in fourteen specialties, including ten in the top five nationwide, and is one of just twenty hospitals to earn a place on the *U.S. News'* 2017-2018 Honor Roll. The following table summarizes the Clinic's national rankings by medical specialty:

Cleveland Clinic Children's Hospital located on the Clinic's main campus ranked as one of the top pediatric hospitals in the country. The Children's Hospital earned national recognition in nine out of ten medical specialties ranked by *U.S. News and World Report* in its 2017-2018 edition of "Best Children's Hospitals." The following table summarizes the Clinic's national rankings by pediatric specialty:

The publication also evaluated hospitals by state and metropolitan area with a methodology similar to that used to determine the national rankings. The Clinic was ranked as the best hospital in both the State of Ohio and the Cleveland metropolitan area, which includes the City of Cleveland and its surrounding suburbs. The report also ranked four of the System's regional hospitals in the top hospitals in the Cleveland metropolitan area and Ohio: Fairview Hospital ranked third in Cleveland and sixth in Ohio; Hillcrest Hospital ranked fourth in Cleveland and seventh in Ohio; and Marymount and South Pointe Hospitals both ranked sixth in Cleveland and twenty-fourth in Ohio. Akron General Medical Center, located in Summit County, was ranked tenth in the State of Ohio. Weston Hospital was ranked second in the Miami-Fort Lauderdale metro area and eighth out of more than 250 hospitals in the State of Florida.

In 2018, the Clinic was named one of the World's Most Ethical Companies by the Ethisphere Institute for the sixth consecutive year. Ethisphere Institute is a global leader in defining and advancing the standards of ethical business practices. The award recognizes organizations that promote ethical business standards and practices internally, enable managers and employees to make good choices and shape future industry standards by introducing best practices. Companies were evaluated in five categories: ethics and compliance programs; corporate citizenship and responsibility; culture of ethics; governance; and leadership, innovation and reputation.

Akron General Medical Center achieved its second Magnet status recognition from the American Nurses Credentialing Center. Magnet

status is the highest national credential for nursing excellence and serves as the gold standard for nursing practice. Organizations that have achieved Magnet status are recognized for quality in patient care, nursing excellence and innovations in professional nursing practice. Akron General is the System's fifth hospital to receive Magnet designation. The Clinic received its first designation in 2003, Fairview Hospital was designated in 2009, Hillcrest was designated in 2014, and South Pointe was designated in 2017. Akron General first designation of Magnet status was received in 2013.

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

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

CORPORATE GOVERNANCE

The Board of Directors of the Clinic is responsible for all of its operations and affairs and controls its property. The Board of Directors is also responsible for ensuring that the Clinic is organized, and at all times operated, consistent with its charitable mission and its status as an Ohio nonprofit corporation and tax-exempt charitable organization. The Board of Directors generally meets five times per year, including an annual meeting during which the Clinic's officers are elected and standing committees are appointed. The size of the Board of Directors can range between 15 to 30 Directors (currently there are 28 Directors). The Board of Trustees serves as an advisor to the Board of Directors. The Trustees actively serve on the committees of the Board of Directors. At present, there are 72 active Trustees and 14 Emeritus Trustees (not including Directors). Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

Marymount Hospital
Garfield Heights, Ohio

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

Medina Hospital – Medina, Ohio

APPOINTMENTS

Tomislav "Tom" Mihaljevic, MD was appointed Chief Executive Officer (CEO) and President of the Cleveland Clinic effective January 1, 2018. Dr. Mihaljevic replaced Toby Cosgrove, MD, who transitioned out of the CEO role in 2017 and now serves in an advisory role. Dr. Mihaljevic joined the Clinic in 2004 as a cardiothoracic surgeon specializing in minimally invasive and robotically assisted cardiac surgeries. Since 2015, Dr. Mihaljevic had served as CEO of Cleveland Clinic Abu Dhabi, overseeing the hospital's strategy and operations, including directly managing the hospital's patient experience and strategy and business development programs. Dr. Mihaljevic's early experiences include medical studies and training in Croatia and Switzerland, a surgical residency at Boston's Brigham and Women's Hospital, and leadership and teaching roles at Harvard Medical School. He is the author or co-author of more than 145 articles in medical and peer-reviewed scientific journals and is the author of numerous textbook chapters on robotic and minimally invasive mitral valve surgery and heart valve disease.

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

Rakesh Suri, MD was appointed Chief Executive Officer of Cleveland Clinic Abu Dhabi in January 2018 as Dr. Mihaljevic transitioned into the Clinic CEO role. Dr. Suri joined the Clinic in 2015 and served as Chief of Staff of Cleveland Clinic Abu Dhabi, where he led the recruitment of more than 400 physicians and participated in the opening and initiation of clinical services through the hospital. Dr. Suri's early experiences include medical studies and training in Canada and the United Kingdom.

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

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

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

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

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 began in the fourth quarter of 2016. These phases include thirty hard-walled and ten curtained holding rooms, a preparation and recovery area with 20 bed spaces that opened in 2016, a newly renovated ultrasound department that includes adult and pediatric scanning that also opened in 2016, a state of the art myelogram room,

gastrointestinal department and general diagnostic departments with sub-waiting and changing areas. The entire project is expected to be completed in 2018 with a total estimated cost of approximately $86 million.

Enterprise Administrative Patient Management - The System is currently in the midst of a multi-year project to align revenue cycle support services and processes to support patients as they progress through their continuum of care. The Enterprise Administrative Patient Management (EAPM) project will consolidate thirteen different technology systems used for scheduling appointments, admissions, electronic medical records, billing and collections into one technology platform with the goal of improving patient experiences. Reducing the number of systems is expected to improve patient service and employee efficiency. Implementation of EAPM began in the first quarter of 2012 at the System facilities in Weston, Florida. The Clinic's main campus and family health centers implemented EAPM in the first quarter of 2016. Marymount and Medina Hospitals implemented EAPM in the second quarter of 2017, Akron General Medical Center and Lodi Hospital implemented EAPM in the third quarter of 2017, and Fairview and Lutheran Hospitals implemented EAPM in the second quarter of 2018. Implementation for the other System hospitals is planned in phases throughout the remainder of 2018. EAPM is expected to require capital costs of approximately $186 million over the entire implementation period, most of which have already been incurred and paid.

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

Coral Springs Family Health Center and Surgery Center - Cleveland Clinic Florida has partnered with a local Florida developer in a joint venture to construct a new Family Health Center and Surgery Center in Coral Springs, Florida. Coral Springs is approximately twenty miles northeast of the Weston campus. This new 74,000 square foot facility will accommodate approximately forty exam rooms, four operating rooms with shell space for two additional operating rooms in the future, two endoscopy rooms and imaging services. Design began in the second quarter of 2016, and construction is projected to be completed in the third quarter of 2018 with a total estimated cost of $32 million. The joint venture obtained a loan for the majority of the construction costs. Cleveland Clinic Florida will lease the facility upon completion of construction.

Akron General Emergency Department – In 2015, Akron General Medical Center began site preparations for a two-story, 73,000 square foot emergency department that will triple the size of the current space. The first floor will house the emergency department, and the second floor will contain administrative offices and a clinical decision unit for patients

that need short-term observation care. The facility will have eight triage rooms and 39 treatment rooms for patients, including six high-acuity trauma rooms, an area designated for patients seeking treatment for sexual assault, an expanded behavioral health unit, an imaging department, a separate urgent care area, and an area for quarantining and treating highly contagious patients. The second floor will house a clinical decision unit that will have capacity for up to 18 short-term observation patient beds. The facility is expected to cost approximately $55 million. Construction of the building began in the first quarter of 2017 and is expected to be completed in third quarter of 2018.

Lakewood Family Health Center – In 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 former Lakewood Hospital. The facility will have an emergency department located on the first floor with 16 treatment rooms. On the second and third floors, the facility will have 60 exam rooms. There will also be lab and imaging services to support operations at the facility. The facility is projected to cost approximately $34 million and is scheduled to open in the third quarter of 2018.

Health Education Campus - In 2013, the Clinic and Case Western Reserve University (CWRU) School of Medicine reached an agreement to build a health education campus that will contain CWRU's medical school program and the Cleveland Clinic Lerner College of Medicine. The campus includes a facility that will be located on the Clinic's main campus and will serve as home for the seminar, lecture, and laboratory curriculum taught during the first two years of medical school. Students' clinical training will continue to take place at area hospitals. This initiative is aligned with the future plans of the Clinic's main campus and supports the Clinic's mission and strategic direction. The facility will also house the CWRU Nursing School and School of Dental Medicine. The facility is designed to encourage extensive interaction and collaboration among the professions. Construction of the facility broke ground on October 1, 2015 and is expected to be completed in December 2018, with the first students expected to be enrolled in the summer of 2019. CWRU and the Clinic will share in the construction costs of approximately $449 million and the ongoing operational costs of the facility, with a portion of the construction costs expected to be raised through fundraising efforts and donations. Plans also include a separate three-story, 126,000 square-foot dental clinic that will be adjacent to the medical school facility and will cost approximately $66 million. The dental clinic will provide a space where students can treat patients under dental faculty supervision. Construction of the dental clinic broke ground in October 2017, and the facility is expected to open at the same time as the medical school.

Cleveland Clinic Children's – In 2017, the Clinic started a transformation of the former Taussig Cancer Building on the Clinic's main campus into an outpatient facility for Cleveland Clinic Children's. The project consolidates multiple locations and specialties of Cleveland Clinic Children's ambulatory care into the existing building, including primary and specialty outpatient services, a children's retail pharmacy, pediatric lab services and pediatric radiology services with x-ray and ultrasound testing. It will also feature a family focused education center, sibling drop-off, pediatric nutrition center, an expanded front entrance on Euclid Avenue, and new technologies focused on enhancing the care and experience for patients, families and caregivers. The 120,000 square foot facility is

expected to have 60 exam rooms, 20 infusion rooms, and four procedure rooms. Outpatient services will include adolescent medicine, allergy and immunology, behavioral health, cardiology and CT Surgery, dermatology, developmental medicine, endocrinology/diabetes, fetal care center, gastroenterology, general surgery, genetics, gynecology, hematology/oncology, infectious disease, integrative medicine, maternal fetal medicine, nephrology, neurology and neurosurgery, otolaryngology, physical medicine and rehabilitation, plastic surgery, primary care, psychiatry, pulmonary medicine, sleep disorders and urology. The renovation project including building infrastructure upgrades is projected to cost approximately $36 million and is scheduled to open in the third quarter of 2018.

Medina Hospital Renovations – In 2017, Medina Hospital completed a $5.8 million renovation of its emergency department, expanding from 14 beds to 19 beds in all private rooms. The renovation also included three rooms for behavioral health patients, a new family consultation room and a new decontamination space for patients who sustained injuries from chemical spills. Medina Hospital also made more than $1.7 million in upgrades in renovations of its intensive care unit in 2017, and recently announced a $4.1 million investment in a new medical-surgical unit that is expected to be completed in the fourth quarter of 2018. The System has invested more than $105 million in improvements to Medina Hospital since it joined the System in 2009, including new operating rooms, a wound center clinic and other outpatient services.

PHILANTHROPY CAMPAIGN

The Clinic publicly launched "The Power of Every One" philanthropic campaign in June 2014 with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the Clinic to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. As of March 31, 2018, the Clinic has received pledges, cash and other assets of approximately $1.4 billion toward the goal.

The $2 billion campaign is divided into four categories: promoting health ($800 million), advancing discovery ($700 million), training caregivers ($400 million) and transforming care ($100 million). Promoting health will focus on improving patient experience and supporting construction and renovation projects, renovation of vacated space, new facilities in Florida and other building projects at 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 AND VENTURES

Cleveland Clinic Innovations promotes scientific, clinical and administrative creativity throughout the System into products that benefit patients around the world. Specifically, it helps to grow the Clinic's innovative capacity, mentors inventors, licenses technology, secures resources, and establishes spin-off companies and strategic collaborations with corporate partners. Since 2000, Cleveland Clinic Innovations has launched 84 companies, transacted more than 544 technology licenses, filed over 3,900 patent applications with over 1,400 issued patents, and acted on approximately 3,600 new inventions. In 2017, Cleveland Clinic executed 43 transactions to provide Cleveland Clinic inventions to external organizations for development and commercialization in various fields, including orthopaedics, telemedicine, cardiovascular, immunology and concussion management.

In 2017, a team led by Andre Machado, MD, PhD performed the nation's first deep brain stimulation for stroke recovery. Enspire DBS, a portfolio company, was spun off in 2010 to develop and commercialize the method used in the procedure. NaviGate Cardiac Structures Inc., another portfolio company, reported the world's first successful implantation of a transcatheter tricuspid valve stent in a patient at the Clinic. NaviGate developed the GATE™ tricuspid AVS based on a license of the seminal technology from the Clinic. Also in 2017, two First-in-Man studies were successfully completed in Germany using the Kapsus catheter, a novel trans-septal puncture device developed by Bavaria Medizin Technologie GmbH (BMT), based on licensed technology invented by Samir Kapadia, MD of the Heart and Vascular Institute.

Cleveland Clinic Ventures operates in tandem with Cleveland Clinic Innovations to turn medical breakthrough inventions into products and companies. The strategy of Cleveland Clinic Ventures is to maximize the success and sustainability of spin-offs and to raise funds that help get ideas to market through funding strategies and business model development.

Cleveland Clinic Innovations manages the Healthcare Innovations Alliance, a collaborative network of healthcare systems, academic institutions and industry partners from around the nation. Alliance partners utilize the Clinic's comprehensive technology and commercialization experience to turn medical ideas into marketable inventions and commercial ventures. The integration of capabilities between organizations is focused on discovery, development and rapid deployment of new technologies with the goal of improving patient care. In 2017, a new product development partner was added to the Alliance to bring expertise in electronics manufacturing to select Cleveland Clinic inventions. In October 2017, Cleveland Clinic Innovations announced a partnership between the Clinic, Jumpstart Inc., and Plug & Play, a Silicon Valley-based accelerator. With the Clinic's support, Plug & Play launched a new HealthTech Accelerator located at the Global Center for Health Innovation in downtown Cleveland in March 2018. The accelerator connects innovative healthcare companies from all over the nation with investors and corporate partners.

Cleveland Clinic Innovations hosts an annual Medical Innovation Summit for industry leaders, investors, and entrepreneurs looking to expand their understanding of the healthcare market and the future of medical innovation. The 2017 Medical Innovation Summit was held in October 2017 in downtown Cleveland. The Summit and its affiliated events had approximately 2,600

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

Cleveland Clinic Innovations operates a 50,000-square-foot Global Cardiovascular Innovation Center (GCIC) on the Clinic's main campus, which is home to its operations, as well as an incubator facility for approximately 30 companies. GCIC has supported the development of over 50 technologies and the creation of over 1,000 new jobs.

CLINICAL AFFILIATIONS

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

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

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

JOINT VENTURES

Under a joint venture agreement with Select Medical, the Clinic and Select Medical operate three rehabilitation hospitals in Northeast Ohio. The first hospital opened in December 2015 in Avon, Ohio. A second facility opened in Beachwood, Ohio in October 2017 and a third-facility opened in Bath Township, Ohio in November 2017, which is the successor location for the Edwin Shaw Rehabilitation Institute. Each facility has 60 beds and features private rooms and the latest rehabilitation equipment to care for patients with stroke, spinal cord injury, brain injury, and a variety of medical and surgical conditions. These facilities expand inpatient rehabilitation services in Northeast Ohio and improve access for patients with complex rehabilitation needs. Select Medical is one of the nation's largest providers of post-acute care services and has partnerships with academic medical centers around the country. The Clinic is a minority member in the joint venture.

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

ACCOUNTABLE CARE ORGANIZATION

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

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

CO-BRANDED INSURANCE

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

In November 2017, Humana Inc., a leading health and well-being company, and the Clinic announced the creation of two new $0 premium Medicare Advantage health plans. The Humana Cleveland Clinic Preferred Medicare Plans will offer patient-centered, affordable access to expert doctors, nurses and facilities for people with Medicare in Cuyahoga County. The collaboration integrates Humana's Medicare Advantage experience with the Clinic's clinical expertise. The plans offer a $0 monthly premium, $0 primary care physician office visit copay, $0 copay for a 30-day supply of Tier-1 prescription drugs and require no referrals to see in-network specialists. Plan members will have access to the Health System's physicians, specialties and facilities, as well as independent physicians who are part of the Cleveland Clinic Quality Alliance.

LAKEWOOD HOSPITAL ASSOCIATION

The Lakewood Hospital Association (LHA) is a non-obligated affiliate of the System. The Clinic, LHA and the City of Lakewood entered into an agreement in December 2015 that outlines the transition of healthcare services in the City of Lakewood and how the Clinic can be a leader in meeting those healthcare needs. Participation in the agreement by the City of Lakewood was authorized by an ordinance adopted by Lakewood City Council. Under the terms of the agreement, the Clinic and LHA will make contributions over the next 16 years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Clinic will construct, own and operate an approximately 62,000-square-foot family health center expected to open in the third quarter of 2018 that will be located adjacent to the site of the former hospital. LHA ceased inpatient operations at the hospital in February 2016, while the current emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The Lakewood Hospital site is currently leased by LHA from the City of Lakewood, and clinical services at that location are operated by the Clinic since the cessation of inpatient operations. The lease has been amended and is expected to terminate approximately thirty to sixty days after the

opening of the family health center and emergency department.

Prior to the signing of the agreement, a lawsuit was filed against the Clinic, LHA, the City of Lakewood and others (Defendants) by a few Lakewood residents (Plaintiffs) seeking to stop the closure of the hospital and money damages. The trial court dismissed the case on July 10, 2017, but the Plaintiffs appealed the dismissal. On May 10, 2018, the Court of Appeals affirmed the decision of the trial court. The decision of the Court of Appeals may be appealed to the Ohio Supreme Court within 45 days. The Supreme Court would not necessarily be obligated to accept an appeal of this case.

In November 2015, Lakewood voters defeated a proposed charter amendment that would have required voter approval on any Lakewood City Council ordinance that would have caused the hospital to no longer be a full time and full service hospital. As a result of duly signed petitions, a referendum vote to repeal the ordinance occurred in November 2016. The results upheld the ordinance adopted by Lakewood City Council.

OTHER LITIGATION

In April 2018, a Cuyahoga County Common Pleas Court jury found in favor of a former Clinic physician that had filed an age discrimination lawsuit against the Clinic. The lawsuit claimed the physician was pressured to retire in 2015 at age 77. The judgment includes economic compensatory damages, emotional distress damages and punitive damages, which are capped under Ohio's tort reform laws. The Clinic has 30 days to appeal the judgment. The Clinic does not expect the impact of any payments related to this lawsuit to be material to the System's consolidated financial results.

AKRON GENERAL HEALTH SYSTEM

In November 2015, the Clinic became the sole member of Akron General Health System (Akron General), an integrated healthcare delivery system with a 532-registered bed flagship medical center located in Akron, Ohio. In addition to the flagship medical center, Akron General also includes Lodi Community Hospital, three health and wellness centers, Visiting Nurse Services and affiliates, a physician group practice and other outpatient locations. As part of the original affiliation agreement, the Clinic and Akron General committed to additional funding for the capital expenditure needs to support Akron General's capital plan for at least the first five years after the member substitution. Initiatives include a new emergency department at Akron General Medical Center that started construction in the first quarter of 2017, two new outpatient centers in the surrounding Akron area and replacement of Akron General's electronic medical records system to enhance safety, quality, and patient experience and reduce the overall cost of care. In the third quarter of 2017, Akron General Medical Center and Lodi Hospital implemented EAPM.

During the operational integration process in early 2016, a compliance review conducted by the System of contractual relationships between Akron General and its independent physician practice groups identified a group of physician arrangements that were potentially non-

compliant with the Federal Anti-Kickback Statute and the Limitations on Certain Physician Referrals regulation (commonly referred to as the Stark Law). Any noncompliance may have resulted in false claims to federal and/or state healthcare programs beginning in 2010 and could result in liability of Akron General under the Federal Anti-Kickback Statute, Stark Law, False Claims Act and/or other laws and regulations. The System voluntarily disclosed its concerns about these physician arrangements to the U.S. Department of Justice (DOJ) in May 2016. Akron General and the System have produced information to, engaged in discussions with, and are cooperating with the DOJ and related government authorities in connection with this matter.

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

UNION HOSPITAL

In April 2018, the Clinic through a subsidiary became the sole member of The Union Hospital Association located in Dover, Ohio. The Union Hospital Association operates a hospital and several off-campus satellite services. Union Hospital has more than 100 patient beds, 300 healthcare providers on staff, and 1,100 employees. In addition to Union Hospital, The Union Hospital Association operates Union Physician Services, a hospital-owned physician network and wholly-owned subsidiary with several offices and approximately 30 providers, and Tuscarawas Ambulatory Surgery Center, a majority-owned subsidiary that provides outpatient surgical services.

All services, programs and locations managed and operated by The Union Hospital Association are continuing as the organizations begin the integration process. The integration process will examine the operating processes and procedures at the various entities and look for ways to improve the quality and delivery of care. The Clinic previously maintained an existing relationship for the past several years with Union Hospital through the Telestroke Network, which connects patients to the Clinic's Cerebrovascular Center.

FLORIDA GROWTH

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

In February 2018, the Clinic and Martin Health System entered into an agreement to explore opportunities for Martin Health System to join the System. Martin Health System is a regional not-for-profit, community-based healthcare provider with three acute-care hospitals and a network of outpatient services.

INTERNATIONAL GROWTH

In October 2015, the Clinic through a subsidiary acquired all of the share capital of 33 Grosvenor Place Limited (Grosvenor Place). Grosvenor Place is a limited liability company existing under Luxembourg law and a private company incorporated under Jersey law that has a long-term leasehold interest in a six-story 198,000 square-foot building in London, England. The System has established a plan to convert the building from office space to an approximately 200-bed hospital with eight operating theatres. The System received approval from local authorities in January 2017 to begin conversion of the building into an advanced healthcare facility, which is expected to complete construction in 2020 and open for patients in early 2021.

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

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

STRATEGY

The U.S. healthcare industry is undergoing unprecedented change with the intersection of economic pressure, insurance reform, technological breakthroughs, and demographic shifts. At the center of this change is an accelerating shift in reimbursement models from volume- to value-based and/or risk-based payment. Contributing to the reformation of

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

The System has set forth a strategy that embraces these fundamental shifts and positions the organization for continued leadership and success in meeting its mission and goals in a vastly changing environment. The strategy focuses on the principle of Patients First and contains the following themes designed to transform value and provide for continued growth:

- Continue to thrive as a national and global referral center for the most complex care
- Master community-based care in a framework of population management
- Innovate medical education to prepare the next generation of caregivers
- Leverage the unique assets and capabilities of the System to grow and extend services to other hospitals and health systems

The organization has been pursuing a roadmap of transformation referred to as the Strategic Agenda. The Strategic Agenda calls for fundamental changes in the System's care, operating and business models over several years. The specific roadmap is guided by the strategy and five overarching goals:

Patients First	– continuously improve quality, safety and patient experience
Caregivers	– make the System the best place to work
Affordability	– steward resources
Growth	– responsibly develop to sustain the Clinic's mission
Impact	– make a difference through research, education, innovation and community health

The centerpiece of the Strategic Agenda is a set of key performance indicators and priority initiatives established by leadership and formalized in a strategic agenda management (SAM) system. The purpose of the SAM is to enable leadership to systematically translate the strategy and goals to the priority work of the enterprise. The goal of the SAM is that every clinical and non-clinical area and every individual caregiver will work to align their respective efforts and initiatives to the System's highest priorities.

Enterprise priorities for 2018 include the following:

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

In 2017, the System launched Cleveland Clinic Community Care, a unit created to better enable healthcare providers and teams to take care of patient populations. Cleveland Clinic Community Care is designed to bring primary care providers together under one umbrella — internal

medicine, family medicine, hospital medicine, general pediatrics, wellness, home care and Express Care will all report to the same unit. Primary care physicians will be joined by advanced practice providers and medical assistants, who will be supported by nurses, patient service representatives and care coordinators, working together to meet the needs of a specific group, or panel of patients.

As a major element of delivering value, an important thread through all of the priority initiatives of the clinical enterprise is care affordability – reducing the cost structure so that the System can be price competitive and render care more affordable for patients. In 2013, the System commissioned a Care Affordability Task Force to perform an enterprise-wide cost structure analysis and propose recommendations for transformational cost and efficiency opportunities. The System is structured to monitor continually its use of resources in all clinical, operational and administrative areas. From 2014 to 2017, management estimates that Care Affordability initiatives and other localized efforts enabled over $860 million of improvements in the cost structure. The System continues to develop and implement cost management and containment plans for a more affordable care model and to enable investments in key strategic initiatives. This work is expected to be an ongoing effort.

In parallel with efforts to transform the care model, the System is redefining its relationships with payors/employers and the payment system to match the broader industry trend toward risk-shifting and redesigned payment. The goal of these efforts is to better deliver to the changing demands of payors/employers, while preserving the financial security of the System during the transition. This involves increased forms of risk-taking in payor contracts (from pay-for-value to bundled payment to shared savings) and narrow network arrangements with payor partners. This is evidenced with the recent launching of co-branded insurance products with payor partners in 2018.

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

Caregivers throughout the System continue to identify and pursue ways to improve on every dimension of the organization's performance: relentless pursuit of quality and safety, organization and delivery of care, effectuation of research and education, and the clearly conveyed message of the organization's value to the market. The System is committed to a path not only to respond to the changes in the environment, but also to lead the field with novel approaches that preserve excellence in care while offering sustainable models for others to adopt.

COMMUNITY BENEFIT AND ECONOMIC IMPACT

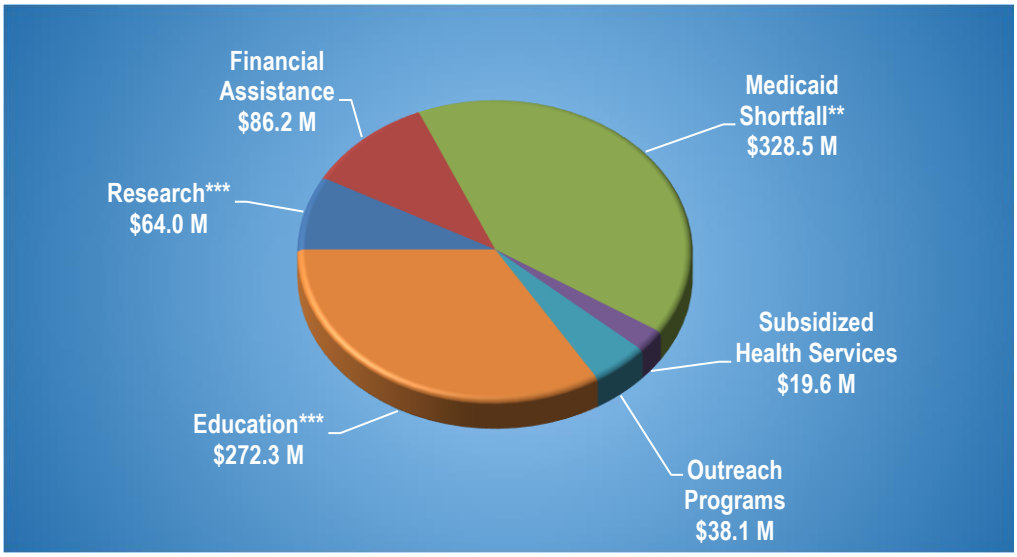
Community Benefit

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

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

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

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



* Includes all System operations in Ohio, Florida and Nevada
** Net of Hospital Care Assurance Program benefit of $3.1 million
*** Research and Education are reported net of externally sponsored funding of $155.0 million.

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

Medicaid Shortfall: The System is a leading provider of Medicaid services in Ohio. The Medicaid program provides healthcare coverage for low-income families and individuals and is funded by both the state and federal governments. Medicaid shortfall represents the difference between the costs of providing care to Medicaid beneficiaries and the reimbursement received by the System. Due primarily to the effects of Medicaid expansion in Ohio, the System is providing more Medicaid services to more patients, which has increased the System's Medicaid shortfall in 2016.

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

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

- The System provided no-cost clinical care to under- and uninsured families at community sites. For example, the Langston Hughes Health and Education Center, a Fairfax neighborhood site, provided multigenerational prevention and wellness services.
- Health fairs provided thousands of people with free screenings for diabetes, heart disease, cancer and other health conditions. The Cleveland Clinic Minority Men's Health Fair, Celebrating Sisterhood, Tu Familia and dozens of other community health fairs educated community members on the benefits of preventive healthcare.
- Wellness initiatives and community education classes were provided to schools, faith-based organizations and community centers in the areas of prevention, chronic disease management and behavioral change, including smoking cessation, weight management, teen parenting, family violence and child safety.
- Collaborative initiatives with community nonprofits and local governments addressed critical population issues, including the opioid epidemic and infant mortality.

- Physical education, training and concussion awareness were provided to high school students by the Clinic's Orthopaedic and Rheumatology Institute. The Pediatric Mobile Unit provided wellness services to local elementary schools.
- The Clinic's Robert J. Tomsich Pathology & Laboratory Medicine Institute donated services to The Free Clinic and Care Alliance, Cleveland area safety-net providers.

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

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

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

Community Health Needs Assessment

The System completes comprehensive community health needs assessments (CHNA) once every three years for each hospital. Internal Revenue Code Section 501(r)(3) requires nonprofit hospital organizations to conduct a CHNA every three years and adopt an implementation strategy to identify the community health needs that each hospital will address.

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

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

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

Key CHNA needs identified throughout the System include:

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

Hospital implementation strategies that address the health needs identified in the assessments have been developed by individual hospital leadership teams and have been added to the Clinic's website in compliance with the regulatory requirements.

The current CHNA reports and implementation strategies for the System hospitals are available on the Clinic's website (www.clevelandclinic.org/CHNAReports).

Economic Impact

According to the System's most recently publicly available 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 publicly available 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 52,000 caregivers, the impact of the System on the community and

ecosystem, both positive and negative, is substantial.

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

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

The Clinic is a member of Practice Greenhealth, the nation's leading healthcare community that empowers its members to increase their efficiencies and environmental stewardship while improving patient safety and care through tools, best practices and knowledge. In 2017, the Clinic was awarded the prestigious "Greening the OR" environmental achievement award offered by Practice Greenhealth for the second year in a row. This award is given to only one healthcare system in the country for its performance in energy efficiency, materials efficiency and recycling in the operating room. In 2018, the Clinic won the Top 25 Environmental Excellence Award, which recognizes healthcare facilities that exemplify environmental excellence and are setting the highest standards for environmental practices in healthcare. Award winners are chosen from hospitals that have the highest scores using Practice Greenhealth's thorough scoring and evaluation system. In 2018, the Clinic was also honored with the Leadership Circle award. The Leadership Circle represents the high-performing hospitals that have a strong infrastructure supporting a long term commitment to healthier environments through leadership vision, committee structure, reporting, data tracking, communication and education. Other System entities and facilities were honored with additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in healthcare sustainability in 2018.

The System's energy program is designed to enhance patient outcomes and the patient experience while reducing operating expenses. As the model of healthcare evolves, the System is committed to reducing environmental, economic and human impact by reducing energy intensity. The System's commitments to both affordable care and external partnerships with ENERGY STAR and the Better Buildings Challenge have created goals of becoming 20% more energy efficient by 2020 from a 2010 baseline on more than 20 million square feet of facilities. Initiatives include a combination of critical energy efficiency projects and broad occupant education and engagement campaigns. From the December 2010 baseline, the System has realized a 15% reduction in weather normalized source energy use intensity for in-scope and reportable facilities.

A central component of the Systems' ongoing commitment to responsible energy management is to construct buildings that conform to the U.S. Green Building Council's Leadership in Energy and Environmental Design (LEED). LEED is a third-party certification program and the nationally accepted benchmark for design, construction and operation of environmentally responsible and energy-efficient buildings. All new major construction projects for the System

follow LEED standards, with a goal of achieving gold certification. Construction projects also emphasize recycling of debris, with current diversion rates of up to 98% in recent years.

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

DIVERSITY

The System provides healthcare services to patients and families from a global community. This makes diversity, inclusion and cultural competence a critical part of the System's mission. In 2007, the System created the Office of Diversity and Inclusion (Diversity). Diversity's mission is to provide strategic direction that builds cultural competence, cultivates an inclusive organization, promotes health equity, develops talent, and supports a diverse population of caregivers and patients. Its programs include cultural competence training, diversity councils, employee resource groups, language enrichment, consultation, and internally and externally focused pipeline development programs.

In 2018, the System was ranked number six on the list of the country's top eleven healthcare organizations for diversity management practices by DiversityInc. The System has made this list for the ninth consecutive year. Rankings are empirically driven and assess performance based on a number of factors including CEO commitment, equitable talent development, talent pipeline and supplier diversity. Additionally, the Clinic was recognized as a "2018 Leader in LGBTQ Healthcare Equality," by the Human Rights Campaign. This distinction was received by meeting criteria for LGBTQ workforce and patient non-discrimination in policy, training, patient care, and access.

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

CONFLICT OF INTEREST

The System maintains policies that require internal reporting of outside financial and fiduciary interests to ensure that potential conflicts of interests do not inappropriately

influence research, patient care, education, business or professional decision making. In connection with these policies, the System developed the Innovation Management and Conflict of Interest Program, which is designed to promote innovation while at the same time reducing, eliminating or managing real or perceived bias either due to System personnel consulting with pharmaceutical, medical device and diagnostic companies (industry) or the commercialization efforts undertaken by the System to develop discoveries and make them accessible to patients. The Program works with investigators who interact with industry to manage any conflicts. Provisions related to whether or not "compelling circumstances" are required to justify conducting research in the presence of related financial interests have been modified in policies that went into effect in 2013, consistent with the value the System places on beneficial relationships with industry. The System is committed to a process that maintains integrity in innovation and places the interests of our patients first. The Innovation Management and Conflict of Interest Program reviews situations in which a physician prescribes or uses products of a company in their practice and has a financial relationship with that company. When appropriate, the Program will put management in place to address any conflict (for example, by disclosure). The goal of this policy is not to interfere with the practice of medicine.

An initiative to bring transparency to the System's relationships with industry was implemented in 2008, in which the specific types of interactions that individual physicians and scientists have with industry were disclosed on publicly-accessible web pages on the System's internet site. Information can be accessed by patients that describes the training, type of practice and accomplishments of a specific doctor or scientist, as well as the names of companies with which the doctor has financial or fiduciary relations as an inventor, consultant, speaker or board member. These disclosures are updated regularly. The System was the first academic medical center in the country to have made these interactions public. Many other academic medical centers have followed the System's lead by providing similar disclosures. The System maintains a Conflict of Interest in Education Policy to reflect its values and represent its and its Staff's best interests. This policy is responsive to guidelines from the Association of American Medical Colleges, the Institute of Medicine and other organizations. It places restrictions on outside speaking activities that are not Accreditation Council for Continuing Medical Education approved and are generally considered marketing. Speakers must present content that is data-driven and balanced; speakers must create their own slides or use only unbranded slides created by industry. This policy puts the System in step with other top academic medical centers that have already banned speaker's bureaus. In addition, the policy requires instructors to disclose relevant financial interests with companies to trainees.

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

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

additional information regarding the Clinic's Board of Directors and any business relationships the Directors may have with the System.

ENTERPRISE RISK MANAGEMENT

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

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

CLEVELAND CLINIC BEACHWOOD
WILLIAM AND BOB RISMAN BUILDING
BEACHWOOD, OHIO

INTERNAL CONTROL OVER FINANCIAL REPORTING

The System regularly evaluates its internal control environment over the System's financial reporting processes through an initiative based upon concepts established in the Sarbanes-Oxley Act of 2002. The goals of the initiative are to ensure the integrity and reliability of financial information, strengthen internal control in the reporting process, reduce the risk of fraud and improve efficiencies in the financial reporting process. The initiative reviews all aspects of the financial reporting process, identifies potential risks and ensures that they have been mitigated utilizing a management self-assessment process. As a result of this initiative, management of the System issued a report on the effectiveness of its internal control over financial reporting as part of the issuance of its consolidated financial results for 2017, which is the ninth year the management report was issued. As part of the internal control evaluation process, certifications are completed by 125 members of System management, including top leadership. The System is one of the first not-for-profit hospitals to issue a management report on the effectiveness of internal control over financial reporting, a step that further increases the transparency of the organization. System management updates the certification on a quarterly basis. There were no changes in internal controls over financial reporting during the three months ended March 31, 2018 that have materially affected, or are likely to materially affect, the internal controls over financial reporting for the System.

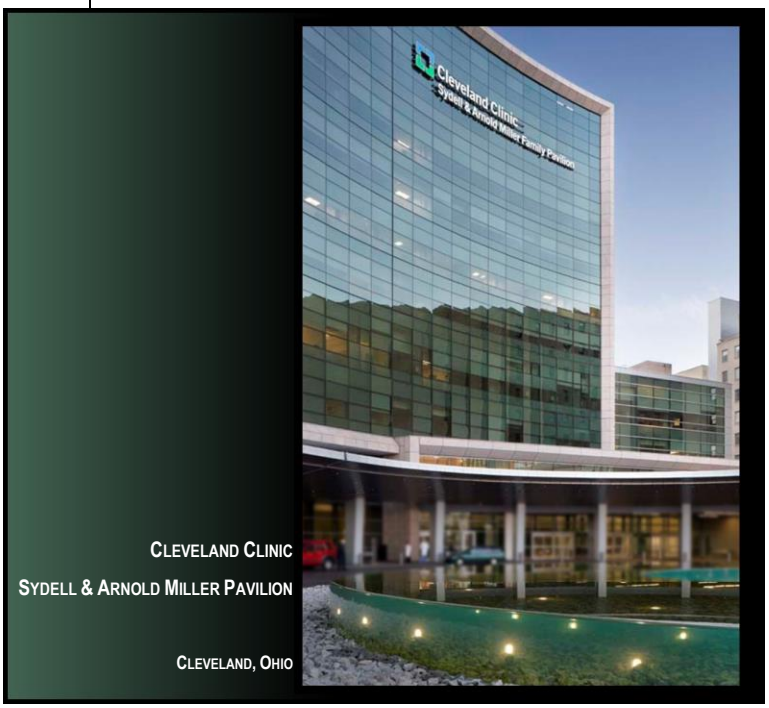
INDUSTRY OUTLOOK

In December 2017, Moody's Investor Services (Moody's) issued a negative outlook for the U.S. not-for-profit healthcare and hospital sector. Moody's revised its outlook from stable, which it had maintained since August 2015. Moody's expects operating cash flow to contract by 2%-4% over the next 12-18 months. The not-for-profit healthcare sector experienced a larger than expected drop in cash flow in 2017, and there is uncertainty about federal healthcare policy. The negative outlook also reflects Moody's expectation that hospital bad debt will continue to rise. Hospitals are experiencing rising co-pays and high deductibles in health plans, which are increasing bad debt. In February 2018, Moody's stated that it expected not-for-profit hospitals to face a risk of volume declines and margin erosion due to commercial insurers acquiring physician practices. Moody's predicts that insurers will be able to provide preventative, outpatient and post-acute care to their members through these providers at a lower cost than hospitals. Moody's also notes that hospitals are facing pressure from insurers moving to value-based payment options with likely lower rate increases that could result in renegotiation or termination of contracts between insurers and hospitals. Moody's expects that hospital mergers, acquisitions and affiliations will remain prevalent as an attempt for hospitals to regain leverage with insurers. In April 2018, Moody's preliminary financial data showed that the nonprofit hospital median operating cash flow decreased from 9.5% for fiscal year 2016 to 8.1% for fiscal year 2017. This is the lowest level seen since the 2008/2009 recession. Overall, the preliminary financial date for fiscal year 2017 is in line with the agency's negative outlook on the nonprofit healthcare and hospital sector.

In January 2018, Standard & Poor's (S&P) maintained its stable outlook for the U.S. not-for-

profit healthcare sector. S&P based its rating on the strength of the balance sheets in the sector being close to historical highs, combined with the long-term trend of market consolidation, physician integration and expanded ambulatory presence, which has helped improve the business positions and prospects for many healthcare organizations. S&P does acknowledge that operating risks for some organizations will increase due to changes in the municipal bond market that will increase the cost of capital and recent legislation to eliminate the Affordable Care Act individual mandate, which will likely put financial pressure on hospitals and health systems. S&P stated that the number of downgrades of its rated nonprofit hospitals and health systems exceeded the number of upgrades in 2017 for the first time since 2014 and the number of downgrades is expected to grow in 2018 for organizations already under pressure.

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



PATIENT VOLUMES

The following table summarizes patient volumes for the System:

Utilization Statistics

	For the quarter ended March 31			
	2018	2017	Variance	%
Inpatient admissions[(1)]				
Acute admissions	41,606	43,067	-1,461	-3.4%
Post-acute admissions	2,628	3,068	-440	-14.3%
	44,234	46,135	-1,901	-4.1%
Patient days[(1)]				
Acute patient days	223,358	222,794	564	0.3%
Post-acute patient days	19,271	25,510	-6,239	-24.5%
	242,629	248,304	-5,675	-2.3%
Surgical cases				
Inpatient	15,660	15,547	113	0.7%
Outpatient	36,601	37,453	-852	-2.3%
	52,261	53,000	-739	-1.4%
Emergency department visits	160,286	161,138	-852	-0.5%
Observations	15,129	15,651	-522	-3.3%
Clinic outpatient evaluation and management visits	1,131,041	1,131,271	-230	0.0%

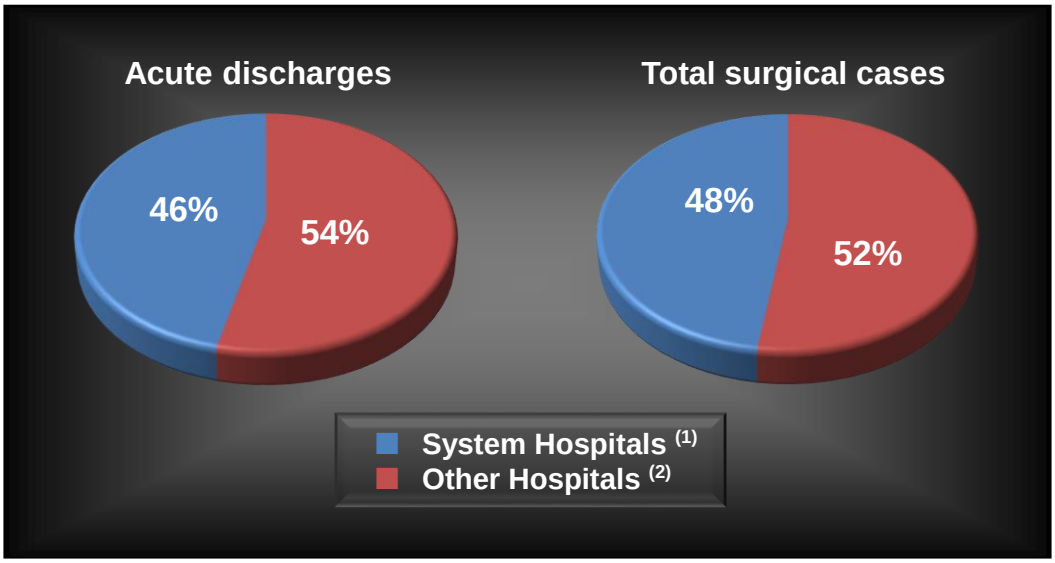
[(1)] Excludes newborns

Inpatient acute admissions for the System decreased 3% in the first quarter of 2018 compared to the same period in 2017. The Clinic experienced a 5% decrease in acute admissions, and the regional hospitals, which include Akron General, collectively experienced a 3% decrease in acute admissions, which resulted in a 4% decrease at the System's facilities in northeast Ohio. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio service area decreased 1% in the first quarter of 2018 compared to the same period in 2017. The Florida facilities experienced a 1% decrease in acute admissions over the same period.

Total surgical cases for the System decreased 1% in the first quarter of 2018 compared to the same period in 2017. Total surgical cases decreased 8% at the Clinic's main campus and

family health centers and increased 4% at the regional hospitals collectively, which resulted in a 1% decrease at the System's facilities in northeast Ohio over the same period. The shift in surgical cases from the main campus and family health centers to the community hospitals is partially due to initiatives at the System to direct lower acuity cases to the community hospital to provide capacity at the main campus for high acuity and more complex cases. According to data from the Center for Health Affairs, total surgical cases in northeast Ohio decreased 1% in the first quarter of 2018 compared to the same period in 2017. The Florida facilities decreased 2% in total surgical cases over the same period. The surgical mix of total surgical cases for the System for the first quarter of 2018 was 30% inpatient and 70% outpatient, which represents an approximately 1% shift from outpatient to inpatient compared to the surgical mix for the same period in 2017.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the three months ended March 31, 2018:



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

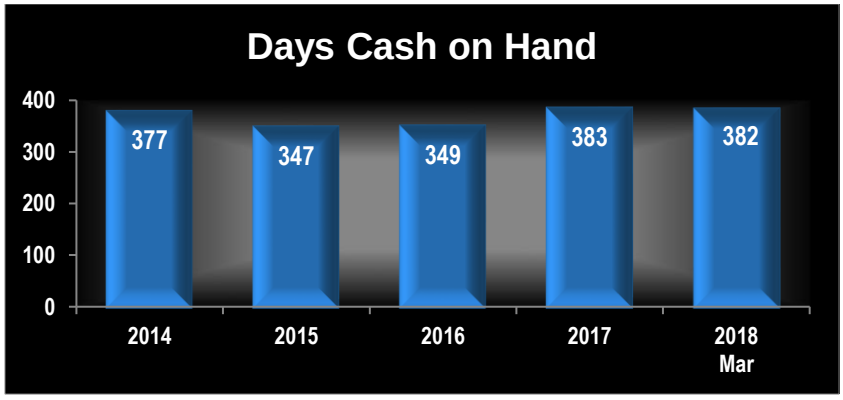
The following table sets forth the allocation of the System's cash and investments at March 31, 2018 and December 31, 2017:

Cash and Investments
(Dollars in thousands)

	March 31, 2018		December 31, 2017	
Cash and cash equivalents	$ 663,793	7%	$ 770,654	8%
Fixed income securities*	2,398,681	27%	2,412,477	27%
Marketable equity securities*	3,193,689	36%	3,192,650	35%
Alternative investments	2,689,104	30%	2,696,560	30%
Total cash and investments	$ 8,945,267	100%	$ 9,072,341	100%
Less restricted investments**	(938,247)		(1,101,417)	
Unrestricted cash and investments	$ 8,007,020		$ 7,970,924	
Days cash on hand	382		383	

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

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



At March 31, 2018, total cash and investments for the System (including restricted investments) were $8.9 billion, a decrease of $127 million from $9.1 billion at December 31, 2017. Cash inflows consist of cash provided by operating activities and related investment income of $77 million and a net increase in restricted gifts and income of $22 million. Cash inflows were offset by net capital expenditures of $159 million and scheduled principal payments on debt of $67 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $164.3 million at March 31, 2018, with an asset mix of 5% cash and short-term investments, 44% fixed-income securities, 34% equity investments and 17% alternative investments. The asset mix reflects the need for liquidity and the objective to maintain stable returns utilizing a lower tolerance for risk and volatility consistent with insurance regulatory requirements.

Also included in the System's cash and investments at March 31, 2018 are $48.2 million of funds held by trustees. Funds held by trustees primarily represent posted collateral related to the System's interest rate swap contracts. The swap contracts require that collateral be posted when the market value of a contract in a liability position exceeds a certain threshold. The collateral is returned as the liability is reduced. Investment objectives of funds held by the trustees are designed to preserve principal by investing in highly liquid cash or fixed-income investments. At March 31, 2018, the asset mix of funds held by trustees was substantially all fixed-income securities.

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

Alternative investments at March 31, 2018 and December 31, 2017 consist of the following:

Alternative Investments
(Dollars in thousands)

	March 31, 2018		December 31, 2017	
Hedge funds	$ 1,344,847	50%	$ 1,357,932	50%
Private equity/venture capital	880,375	33%	854,632	32%
Real estate	463,882	17%	483,996	18%
Total alternative investments	$ 2,689,104	100%	$ 2,696,560	100%

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

Investment Return

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

The System's long-term investment portfolio, which excludes assets held for self-insurance, reported approximately break-even investment returns for the first quarter of 2018, which is higher than the portfolio's benchmark loss of 0.4% and lower than investment gains of 3.6% experienced in the first quarter of 2017.

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

Investment Return
(Dollars in thousands)

	For the quarter ended March 31	
	2018	2017
Other unrestricted revenue:		
Interest income and dividends	$ 627	$ 659
Nonoperating gains and losses, net:		
Interest income and dividends	15,197	14,450
Net realized gains on sales of investments	67,638	24,784
Net change in unrealized gains (losses) on investments	(56,870)	192,554
Equity method income on alternative investments	17,604	18,771
Investment management fees	(6,465)	(7,877)
	37,104	242,682
Other changes in net assets:		
Investment income on restricted investments and other	200	13,569
Total investment return	$ 37,931	$ 256,910

Pension Investments

In 2015, the System updated its investment strategy and modified the allocation of pension plan investments in the CCHS Retirement Plan (Plan), the System's primary defined benefit pension plan. All benefit accruals for participants in the plan ceased by December 31, 2012. Coincident with the updated investment strategy, the System reduced the asset allocation for common and preferred stocks with a corresponding increase in fixed income securities. The updated investment strategy was implemented because of the funded status of the Plan and the anticipation that such changes in investment strategy will result in lower volatility of future changes in funded status. Once the new investment strategy is fully implemented, it is anticipated that the duration of the investment assets will match the liabilities of the Plan over time. Additional revisions in asset allocations may occur based on future changes in the funded status of the Plan. As of March 31, 2018, the Plan's investments were comprised of 7% cash and cash equivalents, 44% fixed-income investments, 30% equities, and 19% alternative investments.

Long-term Debt

At March 31, 2018, outstanding bonds for the System totaled $3.293 billion, comprised of $2.574 billion (78%) of fixed-rate bonds and $719 million (22%) of variable-rate bonds. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds and certain variable-rate

operating lease payments. The total notional amount on the System's interest rate swap contracts at March 31, 2018 was $604 million. Using an interest rate benchmark, these contracts convert variable-rate debt to a fixed-rate, which further reduces the System's exposure to variable interest rates. The interest rate swap contracts can be unwound by the System at any time, whereas the counterparty has the option to unwind the contracts only upon an event of default as defined in the contracts.

Approximately $350 million of the variable-rate bonds are secured by irrevocable direct pay letters of credit or standby bond purchase agreements, and another $16 million is directly placed with a financial institution. Bonds supported by letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year, or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds are classified as current liabilities.

The remaining $352 million variable-rate bonds are supported by the System's self-liquidity program. Bonds supported by self-liquidity include the Series 2014A CP Notes and certain variable-rate bonds that are remarketed in commercial paper mode. Bonds in the self-liquidity program are structured with various term dates so that no more than $50 million of bonds mature within a five-day period. Bonds supported by self-liquidity are classified as current liabilities.

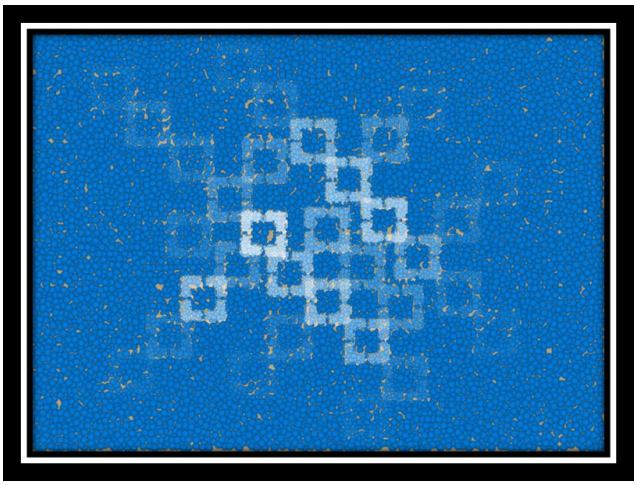
The System maintains the Cleveland Clinic Health System Obligated Group Commercial Paper Program (CP Program), which provides for the issuance of the Series 2014A CP Notes. The CP Program was established in November 2014 and will terminate no later than January 2044. The Series 2014A CP Notes may be issued from time to time in a maximum outstanding face amount of $100 million and are supported by the System's self-liquidity program. At March 31, 2018, the System has $71.0 million of outstanding Series 2014A CP Notes.

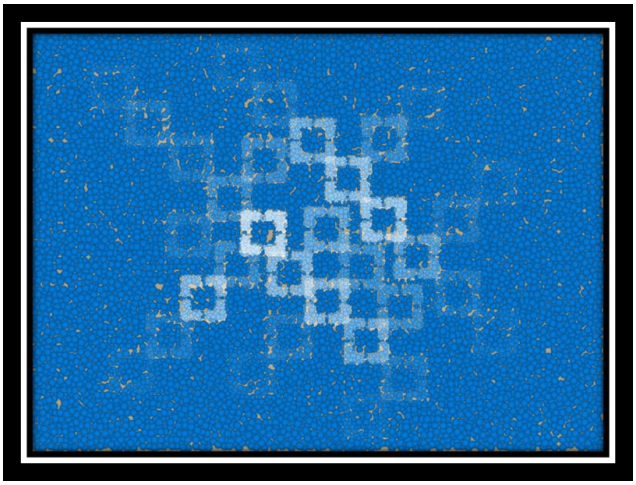
Glickman Tower – Cleveland, Ohio

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

Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	March 31 2018	December 31 2017
2017A	CCHS Obligated Group	Fixed	2043	$ 818,775	$ 818,775
2017B	CCHS Obligated Group	Fixed	2043	169,255	169,255
2017C	CCHS Obligated Group	Fixed	2032	8,945	9,305
2016	CCHS Obligated Group	Fixed	2046	325,000	325,000
2016	CCHS Obligated Group	Variable	2026	16,270	16,270
2014	CCHS Obligated Group	Fixed	2114	400,000	400,000
2014A	CCHS Obligated Group	CP Notes	2044	70,955	70,955
2013A	CCHS Obligated Group	Fixed / Index	2042	62,650	73,150
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	61,165	61,165
2012A	CCHS Obligated Group	Fixed	2039	439,925	451,135
2011A	CCHS Obligated Group	Fixed	2032	148,645	160,605
2011B	CCHS Obligated Group	Fixed	2031	26,380	27,785
2011C	CCHS Obligated Group	Fixed	2032	157,945	157,945
2009B	CCHS Obligated Group	Fixed	2039	16,135	31,640
2008A	CCHS Obligated Group	Fixed	2043	-	7,930
2008B	CCHS Obligated Group	Variable	2043	327,575	327,575
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
				$ 3,292,685	$ 3,351,555



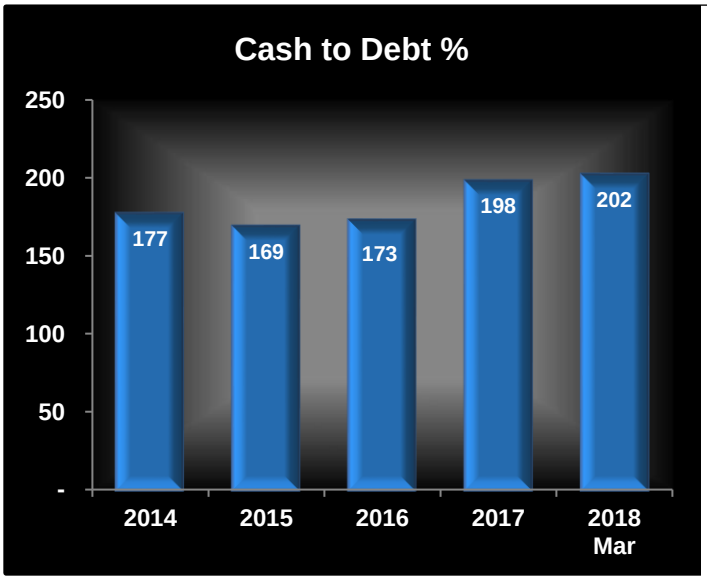


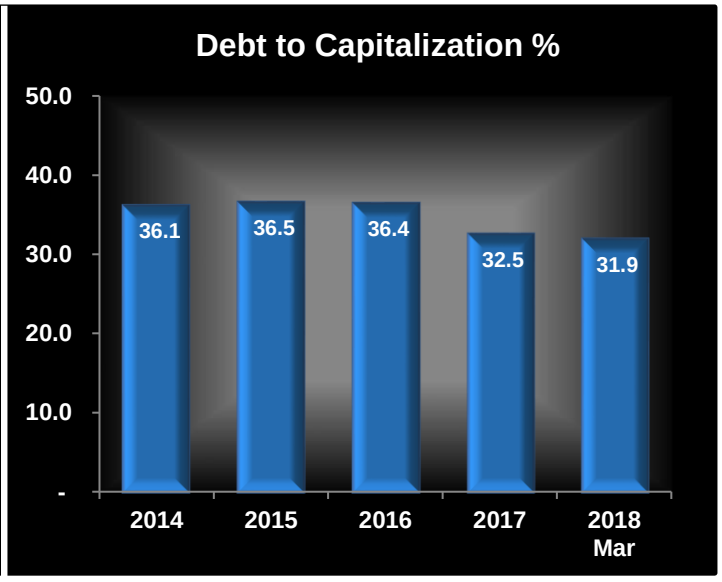
At March 31, 2018, the System has notes payable and capital leases totaling $526.3 million. Notes payable and capital leases include $376.5 million of notes payable, $60.0 million outstanding on a revolving credit facility and $89.8 million of capital lease liabilities primarily related to property and equipment.

Included in notes payable is a term loan entered into by a Clinic subsidiary with a financial institution in 2015 for a principal amount of $375 million. The proceeds of the term loan were used to finance the System's international business strategy. The term loan bears interest at a variable-rate based on the London Interbank Offered Rate (LIBOR) index plus an applicable spread. The Clinic provides a guarantee on the term loan. The term loan was scheduled to mature in April 2018. On April 12, 2018, prior to the maturity date of the original term loan, the term loan was extended for one year.

The Clinic has a $300.0 million revolving credit facility with multiple financial institutions. The revolving credit facility expires in 2019 with provisions allowing the Clinic to extend the term for one-year periods. The facility allows the System to enter into short-term loans that automatically renew throughout the term of the facility. The revolving credit facility bears interest at a variable rate based on the LIBOR index plus an applicable spread. Amounts outstanding on the revolving credit facility as of March 31, 2018 totaled $60.0 million and are recorded in notes payable in the consolidated balance sheets.

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





BOND RATINGS

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

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

Bond Ratings

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

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

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

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended March 31, 2018 and 2017

Operating income for the System in the first quarter of 2018 was $47.6 million, resulting in an operating margin of 2.2%, as compared to operating income of $60.7 million and an operating margin of 2.9% in the first quarter of 2017. The lower operating income resulted from a 3.3% increase in operating expenses, which outpaced total unrestricted revenue growth of 2.6% in the same period. Notable increases in expenses were experienced in salaries, wages and benefits, pharmaceutical costs and supplies.

Nonoperating gains for the System were $58.9 million in the first quarter of 2018 compared to nonoperating gains of $247.9 million in the first quarter of 2017. The increase from the prior year was primarily due to changes in the financial markets. Overall, the System reported an excess of revenues over expenses of $106.5 million in the first quarter of 2018 compared to an excess of revenues over expenses of $308.6 million in the first quarter of 2017.

The System's net patient service revenue increased $40.5 million (2.2%) in the first quarter of 2018 compared to the same period in 2017. The System experienced a decrease in inpatient acute admissions of 3.4%. However, the impact to patient service revenue was mitigated by a strong case mix due to efforts that focused on accurate documentation of patient care and higher acuity patients, which has resulted in more inpatient revenue per patient. Total surgical cases and emergency department visits were lower in the first quarter of 2018 compared to the first quarter of 2017 by 1.4% and 0.5%, respectively, while outpatient evaluation and management visits were flat over the same period. The System has also experienced an increase in Medicare and Medicaid revenue primarily as a result of the Affordable Care Act and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 0.7% in the first quarter of 2018 compared to the same period in 2017. The System has experienced a corresponding decrease in managed care and commercial gross revenues as a percentage of total gross patient revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2018. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Other unrestricted revenues increased $13.1 million (6.5%) in the first quarter of 2018 compared to the same period in 2017. The increase in other unrestricted revenues was primarily due to a $10.1 million increase in outpatient pharmacy revenue, a $7.0 million increase in unrestricted gifts and assets released from restriction and a $6.0 million increase in research and education grant revenue. These increases were offset by a $2.8 million gain on the sale of a CCF Innovations spin-off company recorded in the first quarter of 2017 and a $1.6 million decrease in equity earnings on joint venture investments.

Total operating expenses increased $66.7 million (3.3%) in the first quarter of 2018 compared to the same period in 2017. Notable increases in expenses were experienced in salaries, wages and benefits, pharmaceutical costs and supplies. To address the growth in expenses caused by inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System has implemented Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. The System continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries, wages and benefits increased $26.0 million (2.2%) in the first quarter of 2018 compared to the same period in 2017. Salaries, excluding benefits, increased $33.5 million (3.4%) due to annual salary adjustments averaging 2-3% across the System that were

awarded in the second quarter of 2017 and a 2.2% increase in average full-time equivalent employees in the first quarter of 2018 compared to the same period in 2017. Benefit costs decreased $7.5 million (4.1%) during the same period. The System experienced a $10.4 million decrease in employee healthcare costs primarily due to a shift in healthcare services from external providers to providers within the System. This decrease was offset by a $3.4 million increase in defined contribution expenses and a $2.7 million increase in FICA expenses primarily due to the increase in salaries and full-time equivalent employees.

Supplies expense increased $9.6 million (4.9%) in the first quarter of 2018 compared to the same period in 2017. The System experienced a $8.6 million increase in implantables and other medical supplies and a $1.0 million increase in non-medical supplies.

Pharmaceutical costs increased $30.6 million (13.7%) in the first quarter of 2018 compared to the same period in 2017. The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $9.1 million in the first quarter of 2018 compared to the same period in 2017. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $2.1 million (1.7%) in the first quarter of 2018 compared to the same period in 2017. The System experienced a $4.8 million decrease in purchased medical services primarily related to external lab services and a $6.9 million increase in purchased non-medical service costs primarily related to $4.2 million increase in software and hardware technology costs and other various costs associated with certain System projects and initiatives.

Administrative services decreased $4.1 million (9.2%) in the first quarter of 2018 compared to the same period in 2017. The decrease in administrative services was primarily due to a $2.0 decrease in consulting fees and professional services for certain System projects and initiatives.

Facilities expense increased $1.9 million (2.2%) in the first quarter of 2018 compared to the same period in 2017. The increase in facilities expense was primarily due to a $1.9 million increase in repairs and maintenance expenses and a $1.7 million increase in utility costs. These increases were offset by a $1.6 million decrease in facility costs associated with 33 Grosvenor Place as the building was vacated in early 2017.

Insurance expense decreased $0.3 million (1.4%) in the first quarter of 2018 compared to the same period in 2017. The decrease in insurance expense was primarily due to a decrease in professional malpractice expense based on actuarial estimates of expected loss claims for each period. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has

reduced claim expenses and has resulted in more favorable settlements.

Interest expense decreased $3.2 million (8.8%) in the first quarter of 2018 compared to the same period in 2017. The decrease is primarily due the issuance of the Series 2017A Bonds and the Series 2017B Bonds in the third quarter of 2017 that refunded $1.1 billion of fixed-rate bonds at a lower interest rate. The System has also made $67.0 million of principal payments on bonds, notes and capital leases in the first quarter of 2018 that has reduced the amount of outstanding debt.

Depreciation and amortization expenses increased $5.2 million (4.3%) in the first quarter of 2018 compared to the same period in 2017. Changes in depreciation include property, plant and equipment that was fully depreciated in 2017, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2018.

Special charges decreased $1.1 million (57.4%) in the first quarter of 2018 compared to the same period in 2017. The System incurred and recorded $0.8 million and $1.9 million of special charges in the first quarters of 2018 and 2017, respectively, related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a description of the terms of the agreement, refer to "LAKEWOOD HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets.

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 $58.9 million in the first quarter of 2018 compared to a net gain of $247.9 million in the first quarter of 2017, resulting in an unfavorable variance of $189.0 million. Investment returns were unfavorable by $205.6 million in the first quarter of 2018 compared to the same period in 2017. The System's long-term investment portfolio reported break-even returns for the first quarter of 2018, which is higher than the portfolio's benchmark loss of 0.4% but lower than investment gains of 3.6% experienced in the first quarter of 2017. Derivative losses were favorable by $13.4 million in the first quarter of 2018 compared to the same period in 2017. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements. The System also experienced a $3.4 million favorable variance in foreign currency transaction gains and losses primarily due to the remeasurement of assets and liabilities from the British Pound to the U.S. Dollar.

BALANCE SHEET – MARCH 31, 2018 COMPARED TO DECEMBER 31, 2017

Patient accounts receivable increased $56.9 million (5.6%) from December 31, 2017 to March 31, 2018. The increase in patient receivables is partially due to the increase in net patient service revenue resulting from rate increases on the System's managed care contracts that became effective in January 2018. The System has also experienced an increase in patient responsibility accounts receivable. Patient responsibility accounts, which represents

the portion of services that is not paid by a patient's insurance company, have increased as a result of employers shifting a greater portion of the cost of care to employees, typically in the form of co-pays and deductibles. These balances are generally more difficult to collect than traditional insurance payors. Patient responsibility accounts receivable also tend to be seasonally higher in the first quarter as many insurance plans have annual deductible requirements. The System has various initiatives to enhance cash collection efforts and create efficiencies in the revenue cycle process, including the implementation of EAPM. EAPM was implemented at the Clinic in 2016 and at four other System hospitals in 2017. Five additional System hospitals have implemented or will be implementing EAPM in 2018. Days revenue outstanding for the System increased from 49 days at December 31, 2017 to 50 days at March 31, 2018.

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

Other current assets decreased $2.6 million (0.7%) from December 31, 2017 to March 31, 2018. The decrease in other current assets was primarily due to collection of various receivables that had been recorded in a prior period offset by an increase in prepaid expenses driven by annual maintenance and insurance contracts.

Unrestricted long-term investments increased $68.2 million (0.9%) from December 31, 2017 to March 31, 2018. The increase was primarily due to a $50.0 million dividend received from the System's captive insurance subsidiary and $21.0 million of interest rate swap collateral returned to the System. Capital expenditures totaled $158.6 million in the first quarter of 2018, which was largely offset by positive cash flow from operations. The System's long-term investment portfolio experienced break-even results for the first quarter of 2018.

Funds held by trustees decreased $21.0 million (30.4%) from December 31, 2017 to March 31, 2018. The decrease in funds held by trustees is primarily due to a $21.0 million decrease in collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance decreased $46.5 million (29.1%) from December 31, 2017 to March 31, 2018. The decrease in self-insurance assets is primarily due the payment of a $50.0 million dividend from the System's captive insurance subsidiary to the Foundation. The dividend was declared in 2017. This decrease was offset by investment gains experienced in the System's captive insurance subsidiary and premiums received by the captive insurance subsidiary.

Donor restricted assets increased $8.3 million (1.2%) from December 31, 2017 to March 31, 2018. The increase in donor restricted assets was primarily from investment gains on restricted investments and the receipt of donor restricted gifts in excess of expenditures from restricted funds.

Net property, plant and equipment increased $17.1 million (0.4%) from December 31, 2017 to March 31, 2018. The System had net expenditures for property, plant and equipment of $158.6 million, offset by depreciation expense of $127.7 million, which includes $0.8 million of accelerated depreciation expense recorded in special charges. Increases in PPE also resulted from $13.4 million of foreign currency translation gains. Capital expenditures in 2018 include amounts paid on retainage liabilities recorded at December 31, 2017 and exclude assets acquired through capital leases and other financing arrangements. Retainage liabilities decreased $30.5 million and new capital leases and other financing arrangements totaled $3.4 million. Expenditures for property, plant and equipment were incurred at numerous facilities across the System and include expenditures for strategic construction, expansion and technological investment as well as replacement of existing facilities and equipment. For a description of many of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets increased $5.6 million (0.8%) from December 31, 2017 to March 31, 2018. The increase in noncurrent assets was primarily due to a $6.0 million increase in pledges receivable.

Accounts payable decreased $91.0 million (18.1%) from December 31, 2017 to March 31, 2018. The decrease in accounts payable was primarily attributable to the timing of payment processing for trade payables, a $30.5 million decrease in retainage liabilities on current construction projects and a $5.2 million decrease in outstanding checks.

Compensation and amounts withheld from payroll increased $30.7 million (8.9%) from December 31, 2017 to March 31, 2018. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $2.5 million (0.5%) from December 31, 2017 to March 31, 2018. The System reclassified regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments made in the first quarter of 2018.

Variable rate debt classified as current did not change from December 31, 2017 to March 31, 2018. Long-term debt classified as current consists of variable-rate bonds supported by the System's self-liquidity program and bonds with letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds.

Other current liabilities decreased $19.8 million (4.5%) from December 31, 2017 to March 31, 2018. The decrease in other current liabilities is primarily due to a $22.0 million decrease in accrued interest payable related to bonds that pay interest semi-annually in January and July of each year and a $6.7 million decrease in deferred revenue related to the international management contracts. These decreases were offset by a $3.6 million increase in third-party liabilities and a $3.6 million increase in accrued employee healthcare liabilities.

Hospital revenue bonds decreased $63.4 million (2.2%) from December 31, 2017 to March 31, 2018. The decrease is primarily due to the reclassification of regularly scheduled principal payments from long-term to current for bond payments due within one year.

Notes payable and capital leases decreased $4.2 million (3.1%) from December 31, 2017 to

March 31, 2018. The System experienced a $2.6 million reduction in capital leases related to an early lease buyout payment on a capital lease. The System also reclassified regularly scheduled principal payments from long-term to current, offset by $3.4 million in new capital leases recorded in the first quarter of 2018.

Professional and general insurance liability reserves decreased $7.9 million (5.3%) from December 31, 2017 to March 31, 2018. The decrease is due to claim liability payments in excess of expenses recorded for the accrual of current year claim estimates.

Terminal Tower
Cleveland, Ohio

Accrued retirement benefits decreased $4.2 million (0.9%) from December 31, 2017 to March 31, 2018. The change in accrued retirement benefits is comprised of a $4.8 million decrease in the System's defined benefit pension plan liabilities and a $0.6 million increase in other postretirement benefit liabilities. The decrease in defined benefit pension plan liabilities was primarily due to net periodic benefit, which is based on actuarial estimates resulting from the expected return on plan assets in excess of interest cost incurred on plan obligations.

Other noncurrent liabilities decreased $24.0 million (4.2%) from December 31, 2017 to March 31, 2018. The decrease in other noncurrent liabilities is primarily due to a $19.8 million decrease in derivative liabilities associated with changes in the fair value of the System's interest rate swap derivative contracts and a $1.1 million decrease in third-party liabilities.

Total net assets increased $131.4 million (1.4%) from December 31, 2017 to March 31, 2018. Unrestricted net assets increased $119.4 million (1.4%) primarily due to an excess of revenues over expenses of $106.5 million, foreign currency translation gains of $13.0 million and assets released from restriction for capital purposes of $0.6 million offset by retirement benefits adjustment of $0.7 million. Temporarily restricted net assets increased $8.6 million (1.3%), primarily due to $22.4 million in temporarily restricted gifts and $0.2 million in net investment income offset by $14.0 million in assets released from restrictions for operations and capital purposes. Permanently restricted net assets increased $3.4 million (1.0%) primarily due to $2.8 million of permanently restricted gifts and a $0.6 million increase in the value of perpetual trusts.

FORWARD-LOOKING STATEMENTS

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

- Changes to the Medicare and Medicaid reimbursement systems resulting in reductions in payments and/or changes in eligibility of patients to qualify for Medicare and Medicaid;
- Legislative reforms or actions that reduce the payment for, and/or utilization of, healthcare services, such as the Patient Protection and Affordable Care Act and/or draft legislation to address reimbursement cuts related to the Sustainable Growth Rate Formulas;
- Possible repeal and/or replacement of the Patient Protection and Affordable Care Act, and repeal of the individual mandate;
- Adjustments resulting from Medicare and Medicaid reimbursement audits, including audits initiated by the Medicare Recovery Audit Contractor program;
- Future contract negotiations between public and private insurers, employers and participating hospitals, including the System's hospitals, and other efforts by these insurers and employers to limit hospitalization costs and coverage;
- Increased competition in the areas served by the System and limited options to respond to the same in part due to uncertainty in the enforcement of antitrust laws;
- The ability of the System to access capital for the funding of capital projects;
- Availability of malpractice insurance at reasonable rates, if at all;
- The System's ability to recruit and retain professionals;
- General economic and business conditions, internationally, nationally and regionally, including the impact of interest rates, foreign currencies, financial market conditions and volatility and increases in the number of self-pay patients;
- The increasing number and severity of cyber threats and the costs of preventing them and protecting patient and other data;
- The declining population in the Greater Cleveland area;
- Impact of federal and state laws on tax-exempt organizations relating to exemption from income taxes, sales taxes, real estate taxes, excise taxes and bond financing, including the Tax Cuts and Jobs Act;
- Management, utilization and increases in the cost of medical drugs and devices as technological advancement progresses without concurrent increases in federal reimbursement;
- Ability of the System to adjust its cost structure and reduce operating expenses; and
- Changes in accounting standards or practices.

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