Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended September 30, 2017

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	September 30 2017	December 31 2016
Assets		
Current assets:		
Cash and cash equivalents	$ 287,843	$ 520,628
Patient receivables, net	951,304	1,059,171
Investments for current use	52,126	52,126
Other current assets	430,328	396,892
Total current assets	1,721,601	2,028,817
Investments:		
Long-term investments	7,486,009	6,476,259
Funds held by trustees	84,097	75,892
Assets held for self-insurance	143,612	128,128
Donor restricted assets	680,025	612,221
	8,393,743	7,292,500
Property, plant, and equipment, net	4,560,501	4,512,078
Other assets:		
Pledges receivable, net	155,662	150,709
Trusts and interests in foundations	72,981	67,219
Other noncurrent assets	378,298	410,007
	606,941	627,935
Total assets	$ 15,282,786	$ 14,461,330

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	September 30 2017	December 31 2016
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 384,303	$ 482,427
Compensation and amounts withheld from payroll	378,288	322,493
Current portion of long-term debt	457,333	81,739
Variable rate debt classified as current	494,415	527,115
Other current liabilities	429,134	462,561
Total current liabilities	2,143,473	1,876,335
Long-term debt:		
Hospital revenue bonds	2,943,528	2,926,949
Notes payable and capital leases	135,312	516,719
	3,078,840	3,443,668
Other liabilities:		
Professional and general insurance liability reserves	152,652	146,109
Accrued retirement benefits	455,798	478,874
Other noncurrent liabilities	466,504	490,545
	1,074,954	1,115,528
Total liabilities	6,297,267	6,435,531
Net assets:		
Unrestricted	8,024,850	7,088,209
Temporarily restricted	634,704	627,426
Permanently restricted	325,965	310,164
Total net assets	8,985,519	8,025,799
Total liabilities and net assets	$ 15,282,786	$ 14,461,330

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended September 30	
	2017	2016
Unrestricted revenues		
Net patient service revenue	$1,916,818	$1,881,773
Provision for uncollectible accounts	(71,546)	(78,483)
Net patient service revenue less provision for uncollectible accounts	1,845,272	1,803,290
Other	203,490	202,630
Total unrestricted revenues	2,048,762	2,005,920
Expenses		
Salaries, wages, and benefits	1,131,857	1,105,213
Supplies	192,609	185,428
Pharmaceuticals	251,243	221,182
Purchased services and other fees	132,570	131,013
Administrative services	43,800	48,437
Facilities	88,928	81,798
Insurance	6,676	15,869
	1,847,683	1,788,940
Operating income before interest, depreciation, and amortization expenses	201,079	216,980
Interest	35,950	34,759
Depreciation and amortization	124,411	120,209
Operating income before special charges	40,718	62,012
Special charges	1,035	3,650
Operating income	39,683	58,362
Nonoperating gains and losses		
Investment return	231,629	232,906
Derivative losses	(2,339)	(2,822)
Other, net	(41,358)	(812)
Net nonoperating gains and losses	187,932	229,272
Excess of revenues over expenses	227,615	287,634

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Total net assets at July 1, 2016	$ 6,738,530	$ 593,552	$ 298,525	$ 7,630,607
Excess of revenues over expenses	287,634	-	-	287,634
Donated capital and assets released from restrictions for capital purposes	2,664	(2,592)	-	72
Gifts and bequests	-	10,659	6,306	16,965
Transfer of net assets	(1,997)	1,997	-	-
Net investment income	-	13,920	-	13,920
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(10,641)	-	(10,641)
Retirement benefits adjustment	(555)	-	-	(555)
Change in interests in foundations	-	697	-	697
Change in value of perpetual trusts	-	-	(2,129)	(2,129)
Net change in unrealized gains on nontrading investments	52	-	-	52
Other	(38,530)	-	-	(38,530)
Increase in net assets	249,268	14,040	4,177	267,485
Total net assets at September 30, 2016	$ 6,987,798	$ 607,592	$ 302,702	$ 7,898,092
Total net assets at July 1, 2017	$ 7,784,092	$ 612,900	$ 317,062	$ 8,714,054
Excess of revenues over expenses	227,615	-	-	227,615
Donated capital and assets released from restrictions for capital purposes	3,301	(3,301)	-	-
Gifts and bequests	-	20,825	8,441	29,266
Transfer of net assets	15	(15)	-	-
Net investment income	-	13,622	-	13,622
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(9,801)	-	(9,801)
Retirement benefits adjustment	(658)	-	-	(658)
Change in interests in foundations	-	474	-	474
Change in value of perpetual trusts	-	-	462	462
Foreign currrency translation	10,559	-	-	10,559
Net change in unrealized gains on nontrading investments	(75)	-	-	(75)
Other	1	-	-	1
Increase in net assets	240,758	21,804	8,903	271,465
Total net assets at September 30, 2017	$ 8,024,850	$ 634,704	$ 325,965	$ 8,985,519

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Nine Months Ended September 30	
	2017	2016
Unrestricted revenues		
Net patient service revenue	$ 5,838,471	$ 5,596,257
Provision for uncollectible accounts	(243,357)	(240,991)
Net patient service revenue less provision for uncollectible accounts	5,595,114	5,355,266
Other	687,008	579,461
Total unrestricted revenues	6,282,122	5,934,727
Expenses		
Salaries, wages, and benefits	3,447,398	3,333,628
Supplies	585,658	555,407
Pharmaceuticals	709,319	636,705
Purchased services and other fees	392,269	375,338
Administrative services	136,594	140,466
Facilities	251,492	255,677
Insurance	47,500	55,945
	5,570,230	5,353,166
Operating income before interest, depreciation, and amortization expenses	711,892	581,561
Interest	107,834	99,817
Depreciation and amortization	368,785	352,928
Operating income before special charges	235,273	128,816
Special charges	4,419	22,884
Operating income	230,854	105,932
Nonoperating gains and losses		
Investment return	647,764	365,646
Derivative losses	(6,522)	(67,682)
Other, net	(32,639)	(6,455)
Net nonoperating gains and losses	608,603	291,509
Excess of revenues over expenses	839,457	397,441

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, 2016	$6,627,406	$ 586,276	$ 295,316	$ 7,508,998
Excess of revenues over expenses	397,441	-	-	397,441
Donated capital and assets released from restrictions for capital purposes	7,706	(6,702)	-	1,004
Gifts and bequests	-	35,647	12,384	48,031
Transfer of net assets	(391)	391	-	-
Net investment income	-	21,101	-	21,101
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(29,456)	-	(29,456)
Retirement benefits adjustment	(1,664)	-	-	(1,664)
Change in interests in foundations	-	335	-	335
Change in value of perpetual trusts	-	-	(4,998)	(4,998)
Net change in unrealized losses on nontrading investments	(179)	-	-	(179)
Other	(42,521)	-	-	(42,521)
Increase in net assets	360,392	21,316	7,386	389,094
Balances at September 30, 2016	$6,987,798	$ 607,592	$ 302,702	$ 7,898,092
Balances at January 1, 2017	$7,088,209	$ 627,426	$ 310,164	$ 8,025,799
Excess of revenues over expenses	839,457	-	-	839,457
Donated capital and assets released from restrictions for capital purposes	72,007	(72,007)	-	-
Gifts and bequests	-	64,158	14,295	78,453
Transfer of net assets	266	(266)	-	-
Net investment income	-	38,219	-	38,219
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(26,462)	-	(26,462)
Retirement benefits adjustment	(1,975)	-	-	(1,975)
Change in interests in foundations	-	3,636	-	3,636
Change in value of perpetual trusts	-	-	1,506	1,506
Foreign currency translation	27,112	-	-	27,112
Net change in unrealized losses on nontrading investments	(505)	-	-	(505)
Other	279	-	-	279
Increase in net assets	936,641	7,278	15,801	959,720
Balances at September 30, 2017	$8,024,850	$ 634,704	$ 325,965	$ 8,985,519

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Nine Months Ended September 30	
	2017	2016
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 959,720	$ 389,094
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Loss on extinguishment of debt	46,159	3,925
Retirement benefits adjustment	1,975	1,664
Net realized and unrealized gains on investments	(647,545)	(355,297)
Depreciation and amortization	371,428	365,029
Provision for uncollectible accounts	243,357	240,991
Foreign currency translation gain	(27,112)	-
Donated capital	-	(1,004)
Restricted gifts, bequests, investment income, and other	(121,814)	(64,469)
Accreted interest and amortization of bond premiums	(1,455)	(1,371)
Net (gain) loss in value of derivatives	(17,443)	47,683
Changes in operating assets and liabilities:		
Patient receivables	(135,490)	(348,838)
Other current assets	(42,480)	21,699
Other noncurrent assets	30,333	(37,983)
Accounts payable and other current liabilities	(32,049)	28,606
Other liabilities	(36,182)	(97,050)
Net cash provided by operating activities and net nonoperating gains and losses	591,402	192,679
Financing activities		
Proceeds from short-term borrowings, net	-	60,000
Proceeds from long-term borrowings	1,108,832	425,150
Payments for redemption of long-term debt	(1,100,815)	(148,260)
Principal payments on long-term debt	(78,210)	(93,436)
Debt issuance costs	(8,017)	(169)
Change in pledges receivables, trusts and interests in foundations	(1,671)	9,971
Restricted gifts, bequests, investment income, and other	121,814	64,469
Net cash provided by financing activities	41,933	317,725
Investing activities		
Expenditures for property and equipment, net	(413,584)	(426,081)
Net change in cash equivalents reported in long-term investments	(527,734)	(24,237)
Purchases of investments	(1,783,490)	(2,056,803)
Sales of investments	1,857,526	2,163,009
Net cash used in investing activities	(867,282)	(344,112)
Effect of exchange rate changes on cash	1,162	-
(Decrease) increase in cash and cash equivalents	(232,785)	166,292
Cash and cash equivalents at beginning of year	520,628	249,580
Cash and cash equivalents at end of period	$ 287,843	$ 415,872

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

The accompanying unaudited consolidated financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) for interim financial information. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation have been included and are of a normal and recurring nature. Operating results for the three and nine months ended September 30, 2017 are not necessarily indicative of the results to be expected for the year ending December 31, 2017. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2016.

2. Organization and Consolidation

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

The System is the leading provider of healthcare services in northeast Ohio. As of September 30, 2017, the System operates 14 hospitals with approximately 3,900 staffed beds. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by the Foundation. The System operates 21 outpatient Family Health Centers and 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 250 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, is effective for the System as of January 1, 2018. The System is currently evaluating the impact on the consolidated financial statements and the options of adopting using either a full retrospective or a modified approach.

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

3. Accounting Policies (continued)

In March 2017, the FASB issued ASU 2017-07, *Compensation — Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. This ASU requires the service cost component of net periodic benefit cost related to defined benefit pension and postretirement benefit plans to be reported in the same financial statement line as other compensation costs arising from services rendered during the period. The other components of net periodic benefit cost are required to be presented separately from service costs and outside of operating income in the statement of operations. Only the service cost component of net periodic benefit cost will be eligible for capitalization in assets. ASU 2017-07 is effective for the System for annual reporting periods beginning after December 15, 2018 and interim periods within annual reporting periods beginning after December 15, 2019 with early adoption permitted in the first quarter of 2017. Upon adoption, the System is required to apply the new guidance retrospectively to all periods presented in the consolidated financial statements, except for the guidance limiting the capitalization of net periodic benefit costs in assets which is required to be applied prospectively. The System early adopted ASU 2017-07 on January 1, 2017. The adoption of ASU 2017-07 was applied retrospectively to all periods presented in the consolidated financial statements. The impact of adopting ASU 2017-07 for the System when applied retrospectively to the nine months ended September 30, 2016 increased salaries, wages and benefits on the consolidated statement of operations as presented herein by $0.2 million, with a corresponding decrease to operating income and increase to net nonoperating gains. The adoption and retrospective application of ASU 2017-07 had no impact on excess of revenues over expenses or the consolidated balance sheets.

4. Use of Estimates

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

5. Net Patient Service Revenue and Patient Receivables

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

	2017		**2016**	
Medicare	**$ 1,938,536**	**33%**	$ 1,870,477	33%
Medicaid	**515,679**	**9**	430,434	8
Managed care and commercial	**3,306,386**	**57**	3,148,114	56
Self-pay	**77,870**	**1**	147,232	3
	$ 5,838,471	**100%**	$ 5,596,257	100%

5. Net Patient Service Revenue and Patient Receivables (continued)

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

The System records an estimated provision for uncollectible accounts in the year of service for self-pay accounts receivable, which includes patient receivables associated with self-pay patients and deductible and copayment balances for which third-party coverage provides for a portion of the services provided. The System has experienced an increase in Medicare and Medicaid revenue primarily as a result of the Affordable Care Act and other industry trends. Self-pay write-offs decreased $60.1 million in the first nine months of 2017 compared to the same period in 2016. The System does not maintain a material allowance for uncollectible accounts from third-party payors.

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

6. Fair Value Measurements

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

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

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

- Level 2 – inputs to the 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.

6. Fair Value Measurements (continued)

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.

The following tables present the financial instruments measured at fair value on a recurring basis as of September 30, 2017 and December 31, 2016, based on the valuation hierarchy (in thousands):

September 30, 2017	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets				
Cash and investments:				
Cash and cash equivalents	**$ 982,482**	**$ 10**	**$ –**	**$ 982,492**
Fixed income securities:				
U.S. treasuries	**896,381**	**–**	**–**	**896,381**
U.S. government agencies	**–**	**20,082**	**–**	**20,082**
U.S. corporate	**–**	**88,646**	**–**	**88,646**
U.S. government agencies asset-backed securities	**–**	**25,529**	**–**	**25,529**
Corporate asset-backed securities	**–**	**5,374**	**–**	**5,374**
Foreign	**–**	**21,877**	**–**	**21,877**
Fixed income mutual funds	**391,067**	**–**	**–**	**391,067**
Common and preferred stocks:				
U.S.	**408,763**	**1,742**	**–**	**410,505**
Foreign	**292,254**	**1,416**	**–**	**293,670**
Equity mutual funds	**313,411**	**–**	**–**	**313,411**
Total cash and investments	**3,284,358**	**164,676**	**–**	**3,449,034**
Perpetual and charitable trusts	**–**	**47,477**	**–**	**47,477**
Total assets at fair value	**$ 3,284,358**	**$ 212,153**	**$ –**	**$ 3,496,511**
Liabilities				
Interest rate swaps	**$ –**	**$ 133,055**	**$ –**	**$ 133,055**
Foreign currency forward contracts	**$ –**	**$ –**	**$ –**	**$ –**
Total liabilities at fair value	**$ –**	**$ 133,055**	**$ –**	**$ 133,055**

6. Fair Value Measurements (continued)

December 31, 2016	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 687,410	$ –	$ –	$ 687,410
Fixed income securities:				
U.S. treasuries	963,715	–	–	963,715
U.S. government agencies	–	20,270	–	20,270
U.S. corporate	–	167,025	–	167,025
U.S. government agencies asset-backed securities	–	25,102	–	25,102
Corporate asset-backed securities	–	2,829	–	2,829
Foreign	–	44,759	–	44,759
Fixed income mutual funds	222,670	–	–	222,670
Common and preferred stocks:				
U.S.	420,744	2,203	–	422,947
Foreign	265,689	1,372	–	267,061
Equity mutual funds	381,686	–	–	381,686
Total cash and investments	2,941,914	263,560	–	3,205,474
Perpetual and charitable trusts	–	45,350	–	45,350
Total assets at fair value	$ 2,941,914	$ 308,910	$ –	$ 3,250,824
Liabilities				
Interest rate swaps	$ –	$ 139,422	$ –	$ 139,422
Foreign currency forward contracts	$ –	$ 11,076	$ –	$ 11,076
Total liabilities at fair value	$ –	$ 150,498	$ –	$ 150,498

6. Fair Value Measurements (continued)

Financial instruments at September 30, 2017 and December 31, 2016 are reflected in the consolidated balance sheets as follows (in thousands):

	September 30 2017	December 31 2016
Cash, cash equivalents, and investments measured at fair value	**$ 3,449,034**	$ 3,205,474
Commingled funds measured at net asset value	**2,885,150**	2,376,840
Alternative investments accounted for under the equity method	**2,399,528**	2,282,940
Total cash, cash equivalents, and investments	**$ 8,733,712**	$ 7,865,254
Perpetual and charitable trusts measured at fair value	**$ 47,477**	$ 45,350
Interests in foundations	**25,504**	21,869
Trusts and interests in foundations	**$ 72,981**	$ 67,219

Interest rate swaps and forward currency forward contracts (Note 7) are reported in other noncurrent liabilities and other current liabilities, respectively, in the consolidated balance sheets.

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

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

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

6. Fair Value Measurements (continued)

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

The fair value of foreign currency forward contracts is based on the difference between the contracted forward rate and current market foreign currency exchange rates. A credit spread adjustment is included in the valuations to appropriately reflect nonperformance risk. The credit spread adjustment is derived from other comparably rated entities' bonds recently priced in the market.

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

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 $620.0 million and $633.1 million at September 30, 2017 and December 31, 2016, respectively. During the term of these transactions, the System pays interest at a fixed rate and receives interest at a variable rate based on the London Interbank Offered Rate (LIBOR) or the Securities Industry and Financial Markets Association Index (SIFMA). The swap agreements are not designated as hedging instruments. Net interest paid or received under the swap agreements is included in derivative losses in the consolidated statements of operations and changes in net assets.

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 September 30 2017	Notional Amount at December 31 2016
Fixed	2021	3.21%	68% of LIBOR	**31,725**	33,265
Fixed	2024	3.42%	68% of LIBOR	**27,200**	27,800
Fixed	2027	3.56%	68% of LIBOR	**124,303**	128,333
Fixed	2028	5.12%	100% of LIBOR	**37,730**	38,800
Fixed	2028	3.51%	68% of LIBOR	**29,125**	29,965
Fixed	2030	5.07%	100% of LIBOR	**60,825**	60,825
Fixed	2030	5.06%	100% of LIBOR	**60,800**	60,800
Fixed	2031	3.04%	68% of LIBOR	**49,850**	52,625
Fixed	2032	4.32%	79% of LIBOR	**2,300**	2,361
Fixed	2032	4.33%	70% of LIBOR	**4,600**	4,723
Fixed	2032	3.78%	70% of LIBOR	**2,300**	2,361
Fixed	2036	4.90%	100% of LIBOR	**49,725**	49,725
Fixed	2036	4.90%	100% of LIBOR	**78,350**	78,350
Fixed	2037	4.62%	100% of SIFMA	**61,165**	63,135
				$ 619,998	$ 633,068

The System is exposed to fluctuations in various foreign currencies against its functional currency, the U.S. dollar (USD). The System has 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 System had outstanding foreign currency forward contracts, expiring at various dates through September 2017, with a total notional amount of $0 and $75 million at September 30, 2017 and December 31, 2016, respectively. The foreign currency contracts are not designated as hedging instruments.

7. Derivative Instruments (continued)

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

	Derivatives Liability			
	September 30, 2017		December 31, 2016	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 133,055**	Other noncurrent liabilities	$ 139,422
Foreign currency contracts	Other current liabilities	**$ -**	Other current liabilities	$ 11,076

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

Derivatives not designated as hedging instruments	Location of (Loss) Gain Recognized	Quarter ended September 30		Nine months ended September 30	
		2017	2016	2017	2016
Interest rate swap agreements	Derivative losses	**$ (2,926)**	$ (101)	**$ (9,526)**	$ (55,196)
Foreign currency contracts	Derivative gains (losses)	**587**	(2,721)	**3,004**	(12,486)
		$ (2,339)	$ (2,822)	**$ (6,522)**	$ (67,682)

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 September 30, 2017 and December 31, 2016, the System posted $84.1 million and $75.6 million, respectively, of collateral with counterparties that is included in funds held by trustees in the consolidated balance sheets. In addition, if the System were to choose to terminate a derivative contract or if a derivative contract were terminated pursuant to an event of default or a termination event as described in the derivative contract, the System could be required to pay a termination payment to the counterparty.

8. Pensions and Other Postretirement Benefits

The System has four defined benefit pension plans, including two plans assumed by the System from the Akron General member substitution. The CCHS Retirement Plan, the System's primary defined benefit pension plan, ceased benefit accruals as of December 31, 2009 for substantially all employees, with benefit accruals for remaining employees ceasing at various intervals through December 31, 2012. The CCHS Retirement Plan does not cover Akron General employees. Akron General has a defined benefit pension plan covering substantially all of its employees that were hired before 2004 who meet certain eligibility requirements. In 2009, the Akron General defined benefit plan ceased benefit accruals for substantially all nonunion employees. Benefits for union employees ceased at various intervals through 2013 except in certain circumstances. The benefits for the System's defined benefit pension plans are provided based on age, years of service, and compensation. The System's policy for its defined benefit pension plans is to fund at least the minimum amounts required by the Employee Retirement Income Security Act. The System also maintains two nonqualified defined benefit supplemental retirement plans, which cover certain of its employees.

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

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

	Quarter Ended September 30		Nine Months Ended September 30	
	2017	**2016**	**2017**	**2016**
Amounts related to defined benefit pension plans:				
Service cost	$ 49	$ 545	$ 147	$ 1,634
Interest cost	17,836	19,019	53,507	57,056
Expected return on assets	(21,167)	(19,864)	(63,502)	(59,592)
Net amortization and deferral	(420)	(420)	(1,261)	(1,261)
Total defined benefit pension plans	(3,702)	(720)	(11,109)	(2,163)
Defined contribution plans	53,836	53,465	176,245	170,754
	$ 50,134	**$ 52,745**	**$ 165,136**	**$ 168,591**

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

As of September 30, 2017, the System has made contributions of $9.8 million to the defined benefit pension plans. The System expects to make additional contributions of $1.8 million to the defined benefit pension plans for the remainder of 2017.

9. Debt

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

10. Special Charges

The System incurred and recorded special charges of $4.4 million and $22.9 million in the first nine months of 2017 and 2016, respectively. Special charges in the first nine months of 2017 and 2016 include $4.4 million and $15.2 million, respectively, related to Lakewood Hospital and the agreement between the City of Lakewood, Lakewood Hospital Association (LHA) and the Foundation 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 17 years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Foundation will construct, own and operate an approximately 62,000-square-foot family health center expected to open in 2018 that will be located adjacent to the current site of the hospital. LHA ceased inpatient operations at the hospital in February 2016, while the current emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The cessation of inpatient services at the hospital is not considered a discontinued operation since the System provides inpatient hospital services at the Foundation and its subsidiary hospitals in the Northeast Ohio area. Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets. Special charges in the first nine months of 2016 also include $7.7 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place. The System is converting the building from office space to a healthcare facility.

11. Subsequent Events

The System evaluated events and transactions occurring subsequent to September 30, 2017 through November 29, 2017, the date the consolidated financial statements were issued. During this period, there were no subsequent events requiring recognition in the consolidated financial statements, and there were no nonrecognized subsequent events requiring disclosure.

Unaudited Consolidating Balance Sheets

($ in thousands)

	September 30, 2017				December 31, 2016			
	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	$ 29,611	$ 258,232	$ -	$ 287,843	$ 303,101	$ 217,527	$ -	$ 520,628
Patient receivables, net	871,278	119,184	(39,158)	951,304	980,245	105,227	(26,301)	1,059,171
Due from affiliates	7,656	31,457	(39,113)	-	4,091	28	(4,119)	-
Investments for current use	-	52,126	-	52,126	-	52,126	-	52,126
Other current assets	336,906	95,120	(1,698)	430,328	315,650	83,553	(2,311)	396,892
Total current assets	1,245,451	556,119	(79,969)	1,721,601	1,603,087	458,461	(32,731)	2,028,817
Investments:								
Long-term investments	7,057,420	428,589	-	7,486,009	6,090,613	385,646	-	6,476,259
Funds held by trustees	84,097	-	-	84,097	75,892	0	-	75,892
Assets held for self-insurance	-	143,612	-	143,612	-	128,128	-	128,128
Donor restricted assets	648,201	31,824	-	680,025	572,982	39,239	-	612,221
	7,789,718	604,025	-	8,393,743	6,739,487	553,013	-	7,292,500
Property, plant, and equipment, net	3,699,474	861,027	-	4,560,501	3,678,817	833,261	-	4,512,078
Other assets:								
Pledges receivable, net	154,874	788	-	155,662	149,889	820	-	150,709
Trusts and beneficial interests in foundations	64,446	8,535	-	72,981	59,069	8,150	-	67,219
Other noncurrent assets	474,501	56,511	(152,714)	378,298	514,693	51,138	(155,824)	410,007
	693,821	65,834	(152,714)	606,941	723,651	60,108	(155,824)	627,935
Total assets	$13,428,464	$ 2,087,005	$ (232,683)	$15,282,786	$12,745,042	$ 1,904,843	$ (188,555)	$14,461,330

	September 30, 2017				December 31, 2016			
	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	$ 309,922	$ 74,661	$ (280)	$ 384,303	$ 409,699	$ 75,038	$ (2,310)	$ 482,427
Compensation and amounts withheld from payroll	338,654	39,634	-	378,288	291,384	31,109	-	322,493
Short-term borrowings	-	-	-	-	0	0	-	-
Current portion of long-term debt	76,987	380,418	(72)	457,333	75,918	5,893	(72)	81,739
Variable rate debt classified as current	435,544	58,871	-	494,415	466,203	60,912	-	527,115
Due to affiliates	14,633	8,684	(23,317)	-	28	4,091	(4,119)	-
Other current liabilities	351,002	119,929	(41,797)	429,134	388,228	100,635	(26,302)	462,561
Total current liabilities	1,526,742	682,197	(65,466)	2,143,473	1,631,460	277,678	(32,803)	1,876,335
Long-term debt:								
Hospital revenue bonds	2,943,528	-	-	2,943,528	2,926,949	0	-	2,926,949
Notes payable and capital leases	110,419	171,796	(146,903)	135,312	121,896	547,127	(152,304)	516,719
	3,053,947	171,796	(146,903)	3,078,840	3,048,845	547,127	(152,304)	3,443,668
Other liabilities:								
Professional and general insurance liability reserve	56,492	96,160	-	152,652	57,290	88,819	-	146,109
Accrued retirement benefits	412,557	43,241	-	455,798	429,965	48,909	-	478,874
Other noncurrent liabilities	429,436	53,934	(16,866)	466,504	434,093	56,452	-	490,545
	898,485	193,335	(16,866)	1,074,954	921,348	194,180	-	1,115,528
Total liabilities	5,479,174	1,047,328	(229,235)	6,297,267	5,601,653	1,018,985	(185,107)	6,435,531
Net assets:								
Unrestricted	7,030,713	997,585	(3,448)	8,024,850	6,253,358	838,299	(3,448)	7,088,209
Temporarily restricted	610,652	24,052	-	634,704	597,449	29,977	-	627,426
Permanently restricted	307,925	18,040	-	325,965	292,582	17,582	-	310,164
Total net assets	7,949,290	1,039,677	(3,448)	8,985,519	7,143,389	885,858	(3,448)	8,025,799
Total liabilities and net assets	$13,428,464	$ 2,087,005	$ (232,683)	$15,282,786	$12,745,042	$ 1,904,843	$ (188,555)	$14,461,330

See notes to unaudited consolidated financial statements.

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

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

Operations

	Three Months Ended September 30, 2017				Three Months Ended September 30, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 1,754,830	$ 227,608	$ (65,620)	$ 1,916,818	$ 1,720,999	$ 236,598	$ (75,824)	$ 1,881,773
Provision for uncollectible accounts	(58,907)	(12,639)	-	(71,546)	(70,097)	(8,386)	-	(78,483)
Net patient service revenue less provision for uncollectible accounts	1,695,923	214,969	(65,620)	1,845,272	1,650,902	228,212	(75,824)	1,803,290
Other	167,152	75,179	(38,841)	203,490	169,811	82,662	(49,843)	202,630
Total unrestricted revenues	1,863,075	290,148	(104,461)	2,048,762	1,820,713	310,874	(125,667)	2,005,920
Expenses								
Salaries, wages, and benefits	1,062,871	150,051	(81,065)	1,131,857	1,036,545	142,114	(73,446)	1,105,213
Supplies	166,602	26,394	(387)	192,609	159,968	25,742	(282)	185,428
Pharmaceuticals	226,713	24,530	-	251,243	203,758	17,424	-	221,182
Purchased services and other fees	107,980	25,330	(740)	132,570	102,748	43,868	(15,603)	131,013
Administrative services	32,204	16,717	(5,121)	43,800	40,360	14,371	(6,294)	48,437
Facilities	68,955	20,880	(907)	88,928	66,444	16,335	(981)	81,798
Insurance	15,058	7,784	(16,166)	6,676	16,776	28,154	(29,061)	15,869
	1,680,383	271,686	(104,386)	1,847,683	1,626,599	288,008	(125,667)	1,788,940
Operating income before interest, depreciation, and amortization expenses	182,692	18,462	(75)	201,079	194,114	22,866	-	216,980
Interest	32,774	3,176	-	35,950	32,331	2,428	-	34,759
Depreciation and amortization	106,634	17,852	(75)	124,411	102,377	17,832	-	120,209
Operating income (loss) before special charges	43,284	(2,566)	-	40,718	59,406	2,606	-	62,012
Special charges	-	1,035	-	1,035	-	3,650	-	3,650
Operating income (loss)	43,284	(3,601)	-	39,683	59,406	(1,044)	-	58,362
Nonoperating gains and losses								
Investment return	214,874	16,755	-	231,629	216,957	15,949	-	232,906
Derivative losses	(1,758)	(581)	-	(2,339)	(2,180)	(642)	-	(2,822)
Other, net	(43,802)	2,444	-	(41,358)	21	(833)	-	(812)
Net nonoperating gains and losses	169,314	18,618	-	187,932	214,798	14,474	-	229,272
Excess (deficiency) of revenues over expenses	212,598	15,017	-	227,615	274,204	13,430	-	287,634

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 July 1, 2016	$ 6,795,136	$ 838,919	$ (3,448)	$ 7,630,607
Excess (deficiency) of revenues over expenses	274,204	13,430	-	287,634
Donated capital, excluding assets released from restrictions for capital purposes	31	41	-	72
Restricted gifts and bequests	15,511	1,454	-	16,965
Restricted net investment loss	13,068	852	-	13,920
Net assets released from restrictions used for operations included in other unrestricted revenues	(9,353)	(1,288)	-	(10,641)
Contributions from (to) affiliates	(39,218)	39,218	-	-
Retirement benefits adjustment	(555)	-	-	(555)
Change in restricted net assets related to interests in foundations	697	-	-	697
Change in restricted net assets related to value of perpetual trusts	(1,771)	(358)	-	(2,129)
Net change in unrealized gains on nontrading investments	52	-	-	52
Other	33	(38,563)	-	(38,530)
Increase in total net assets	252,699	14,786	-	267,485
Total net assets at September 30, 2016	$ 7,047,835	$ 853,705	$ (3,448)	$ 7,898,092
Total net assets at July 1, 2017	$ 7,736,362	$ 981,140	$ (3,448)	$ 8,714,054
Excess of revenues over expenses	212,598	15,017	-	227,615
Restricted gifts and bequests	28,589	677	-	29,266
Restricted net investment income	12,749	873	-	13,622
Net assets released from restrictions used for operations included in other unrestricted revenues	(8,802)	(999)	-	(9,801)
Transfers (to) from affiliates	(32,371)	32,371	-	-
Retirement benefits adjustment	(658)	-	-	(658)
Change in restricted net assets related to interests in foundations	474	-	-	474
Change in restricted net assets related to value of perpetual trusts	361	101	-	462
Foreign currency translation	63	10,496	-	10,559
Net change in unrealized gains on nontrading investments	(75)	-	-	(75)
Other	-	1	-	1
Increase in total net assets	212,928	58,537	-	271,465
Total net assets at September 30, 2017	$ 7,949,290	$ 1,039,677	$ (3,448)	$ 8,985,519

See notes to unaudited consolidated financial statements.

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

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

($ in thousands)

Operations

	Nine Months Ended September 30, 2017				Nine Months Ended September 30, 2016			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 5,336,898	$ 689,147	$ (187,574)	$ 5,838,471	$ 5,111,405	$ 671,754	$ (186,902)	$ 5,596,257
Provision for uncollectible accounts	(199,747)	(43,610)	-	(243,357)	(212,529)	(28,462)	-	(240,991)
Net patient service revenue less provision for uncollectible accounts	5,137,151	645,537	(187,574)	5,595,114	4,898,876	643,292	(186,902)	5,355,266
Other	579,522	227,175	(119,689)	687,008	472,852	226,472	(119,863)	579,461
Total unrestricted revenues	5,716,673	872,712	(307,263)	6,282,122	5,371,728	869,764	(306,765)	5,934,727
Expenses								
Salaries, wages, and benefits	3,228,052	439,430	(220,084)	3,447,398	3,101,707	435,696	(203,775)	3,333,628
Supplies	509,057	77,450	(849)	585,658	479,600	76,549	(742)	555,407
Pharmaceuticals	646,303	63,016	-	709,319	586,136	50,569	-	636,705
Purchased services and other fees	321,490	90,626	(19,847)	392,269	300,245	96,910	(21,817)	375,338
Administrative services	104,451	47,262	(15,119)	136,594	116,919	42,280	(18,733)	140,466
Facilities	200,642	53,642	(2,792)	251,492	206,207	52,465	(2,995)	255,677
Insurance	50,139	45,858	(48,497)	47,500	50,184	64,464	(58,703)	55,945
	5,060,134	817,284	(307,188)	5,570,230	4,840,998	818,933	(306,765)	5,353,166
Operating income before interest, depreciation, and amortization expenses	656,539	55,428	(75)	711,892	530,730	50,831	-	581,561
Interest	99,302	8,532	-	107,834	92,668	7,149	-	99,817
Depreciation and amortization	321,223	47,637	(75)	368,785	299,342	53,586	-	352,928
Operating income (loss) before special charges	236,014	(741)	-	235,273	138,720	(9,904)	-	128,816
Special charges	-	4,419	-	4,419	969	21,915	-	22,884
Operating income (loss)	236,014	(5,160)	-	230,854	137,751	(31,819)	-	105,932
Nonoperating gains and losses								
Investment return	599,482	48,282	-	647,764	337,970	27,676	-	365,646
Derivative losses	(4,721)	(1,801)	-	(6,522)	(65,612)	(2,070)	-	(67,682)
Other, net	(38,601)	5,962	-	(32,639)	414	(6,869)	-	(6,455)
Net nonoperating gains and losses	556,160	52,443	-	608,603	272,772	18,737	-	291,509
Excess (deficiency) of revenues over expenses	792,174	47,283	-	839,457	410,523	(13,082)	-	397,441

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

($ in thousands)

Changes in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2016	$ 6,676,175	$ 836,271	$ (3,448)	$ 7,508,998
Excess (deficiency) of revenues over expenses	410,523	(13,082)	-	397,441
Donated capital, excluding assets released from restrictions for capital purposes	963	41	-	1,004
Restricted gifts and bequests	45,630	2,401	-	48,031
Restricted net investment income	19,431	1,670	-	21,101
Net assets released from restrictions used for operations included in other unrestricted revenues	(26,788)	(2,668)	-	(29,456)
Contributions (to) from affiliates	(72,089)	72,089	-	-
Retirement benefits adjustment	(1,664)	-	-	(1,664)
Change in restricted net assets related to interest in foundations	335	-	-	335
Change in restricted net assets related to value of perpetual trusts	(4,050)	(948)	-	(4,998)
Net change in unrealized losses on nontrading investments	(179)	-	-	(179)
Other	(452)	(42,069)	-	(42,521)
Increase in total net assets	371,660	17,434	-	389,094
Total net assets at September 30, 2016	$ 7,047,835	$ 853,705	$ (3,448)	$ 7,898,092
Total net assets at January 1, 2017	$ 7,143,389	$ 885,858	$ (3,448)	$ 8,025,799
Excess of revenues over expenses	792,174	47,283	-	839,457
Restricted gifts and bequests	76,976	1,477	-	78,453
Restricted net investment income	35,577	2,642	-	38,219
Net assets released from restrictions used for operations included in other unrestricted revenues	(24,137)	(2,325)	-	(26,462)
Transfers (to) from affiliates	(76,952)	76,952	-	-
Retirement benefits adjustment	(1,975)	-	-	(1,975)
Change in restricted net assets related to interests in foundations	3,636	-	-	3,636
Change in restricted net assets related to value of perpetual trusts	1,126	380	-	1,506
Foreign currency translation	-	27,112	-	27,112
Net change in unrealized losses on nontrading investments	(505)	-	-	(505)
Other	(19)	298	-	279
Increase in total net assets	805,901	153,819	-	959,720
Total net assets at September 30, 2017	$ 7,949,290	$ 1,039,677	$ (3,448)	$ 8,985,519

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)

	Nine Months Ended September 30, 2017				Nine Months Ended September 30, 2016			
	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	$ 805,901	$ 153,819	$ -	$ 959,720	$ 371,660	$ 17,434	$ -	$ 389,094
Adjustments to reconcile increase in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:								
Gain on extinguishment of debt	46,159	-	-	46,159	-	3,925	-	3,925
Retirement benefits adjustment	1,975	-	-	1,975	1,664	-	-	1,664
Net realized and unrealized gains on investments	(598,361)	(49,184)	-	(647,545)	(329,250)	(26,047)	-	(355,297)
Depreciation and amortization	321,223	50,280	(75)	371,428	299,342	65,687	-	365,029
Provision for uncollectible accounts	199,747	43,610	-	243,357	212,529	28,462	-	240,991
Foreign currency translation gain	-	(27,112)	-	(27,112)	-	-	-	-
Donated capital	-	-	-	-	(963)	(41)	-	(1,004)
Restricted gifts, bequests, investment income, and other	(117,315)	(4,499)	-	(121,814)	(61,346)	(3,123)	-	(64,469)
Transfers to (from) affiliates	76,952	(76,952)	-	-	72,089	(72,089)	-	-
Accreted interest and amortization of bond premiums	(1,464)	9	-	(1,455)	(1,369)	(2)	-	(1,371)
Net (gain) loss in value of derivatives	(17,443)	-	-	(17,443)	54,564	(6,881)	-	47,683
Changes in operating assets and liabilities:								
Patient receivables	(90,780)	(57,567)	12,857	(135,490)	(321,032)	(31,667)	3,861	(348,838)
Other current assets	(33,515)	(43,346)	34,381	(42,480)	20,507	(65,187)	66,379	21,699
Other noncurrent assets	39,028	(5,660)	(3,035)	30,333	(168,517)	(42,767)	173,301	(37,983)
Accounts payable and other current liabilities	(41,218)	41,832	(32,663)	(32,049)	30,816	51,621	(53,831)	28,606
Other liabilities	(18,471)	(845)	(16,866)	(36,182)	(99,891)	19,250	(16,409)	(97,050)
Net cash provided by (used in) operating activities and net nonoperating gains and losses	572,418	24,385	(5,401)	591,402	80,803	(61,425)	173,301	192,679
Financing activities								
Proceeds from short-term borrowings, net	-	-	-	-	60,000	-	-	60,000
Proceeds from long-term borrowings	1,108,832	2,099	(2,099)	1,108,832	468,085	145,706	(188,641)	425,150
Payments for advance refunding of long-term debt	(1,100,815)	-	-	(1,100,815)	-	(148,260)	-	(148,260)
Principal payments on long-term debt	(80,644)	(5,066)	7,500	(78,210)	(82,816)	(25,960)	15,340	(93,436)
Debt issuance costs	(8,017)	-	-	(8,017)	(169)	-	-	(169)
Change in pledges receivable, trusts and interests in foundations	(1,668)	(3)	-	(1,671)	8,667	1,304	-	9,971
Restricted gifts, bequests, investment income, and other	117,315	4,499	-	121,814	61,346	3,123	-	64,469
Net cash (used in) provided by financing activities	35,003	1,529	5,401	41,933	515,113	(24,087)	(173,301)	317,725
Investing activities								
Expenditures for property and equipment	(352,089)	(61,495)	-	(413,584)	(422,266)	(3,815)	-	(426,081)
Net change in cash equivalents reported in long-term investments	(576,582)	48,848	-	(527,734)	(83,602)	59,365	-	(24,237)
Purchases of investments	(1,623,799)	(159,691)	-	(1,783,490)	(1,897,058)	(159,745)	-	(2,056,803)
Sales of investments	1,748,511	109,015	-	1,857,526	2,056,059	106,950	-	2,163,009
Transfers (to) from affiliates	(76,952)	76,952	-	-	(72,089)	72,089	-	-
Net cash used in investing activities	(880,911)	13,629	-	(867,282)	(418,956)	74,844	-	(344,112)
Effect of exchange rate changes on cash	-	1,162		1,162				
Increase (decrease) in cash and cash equivalents	(273,490)	40,705	-	(232,785)	176,960	(10,668)	-	166,292
Cash and cash equivalents at beginning of year	303,101	217,527	-	520,628	108,436	141,144	-	249,580
Cash and cash equivalents at end of period	$ 29,611	$ 258,232	$ -	$ 287,843	$ 285,396	$ 130,476	$ -	$ 415,872

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 September 30	
	2014	2015[2]	2016	2016	2017
Total Staffed Beds[1]	3,565	4,034	3,906	3,859	3,943
Percent Occupancy[1]	67.0%	67.9%	69.2%	69.6%	71.1%
Inpatient Admissions[1]					
Acute	140,596	146,990	161,674	122,123	127,631
Post-acute	11,908	11,779	12,487	9,411	9,036
Total	152,504	158,769	174,161	131,534	136,667
Patient Days[1]					
Acute	746,293	782,316	842,403	635,947	660,426
Post-acute	99,701	98,268	105,554	78,382	74,559
Total	845,994	880,584	947,957	714,329	734,985
Average Length of Stay					
Acute	5.28	5.30	5.21	5.22	5.15
Post-acute	8.38	8.30	8.48	8.38	8.26
Surgical Facility Cases					
Inpatient	55,515	56,311	59,760	45,015	46,355
Outpatient	130,706	137,139	147,850	110,831	110,145
Total	186,221	193,450	207,610	155,846	156,500
Emergency Room Visits	497,631	542,768	652,196	491,777	486,456
Outpatient Observations	49,724	49,237	58,385	43,259	45,012
Outpatient Evaluation and Management Visits	3,508,030	3,742,901	4,194,593	3,168,230	3,307,142
Acute Medicare Case Mix Index - Health System	1.90	1.91	1.93	1.93	1.90
Acute Medicare Case Mix Index - Cleveland Clinic	2.47	2.47	2.53	2.52	2.58
Total Acute Patient Case Mix Index - Health System	1.81	1.81	1.84	1.83	1.84
Total Acute Patient Case Mix Index - Cleveland Clinic	2.37	2.36	2.44	2.43	2.50

(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 September 30	
	2014	2015	2016	2016	2017
Total Staffed Beds[(1)]	3,297	3,352	3,387	3,346	3,413
Percent Occupancy[(1)]	68.2%	69.6%	69.7%	70.1%	71.0%
Inpatient Admissions[(1)]					
Acute	134,704	138,287	139,223	104,483	109,760
Post-acute	9,827	9,740	9,487	7,208	6,816
Total	144,531	148,027	148,710	111,691	116,576
Patient Days[(1)]					
Acute	722,977	747,231	744,012	560,649	577,032
Post-acute	71,989	73,473	76,330	57,496	54,185
Total	794,966	820,704	820,342	618,145	631,217
Surgical Facility Cases					
Inpatient	53,764	53,839	54,032	40,729	42,166
Outpatient	127,903	132,800	135,913	101,856	101,023
Total	181,667	186,639	189,945	142,585	143,189
Emergency Room Visits	464,981	493,930	535,599	402,825	399,404
Outpatient Observations	46,409	45,687	50,672	37,259	39,197
Outpatient Evaluation and Management Visits	3,508,030	3,742,901	4,194,593	3,166,128	3,304,099
Acute Medicare Case Mix Index	1.85	1.86	1.96	1.92	1.89
Total Acute Patient Case Mix Index	1.76	1.76	1.87	1.82	1.83

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

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

Payor Mix

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

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD September 30	
	2014	**2015[1]**	**2016**	**2016**	**2017**
Payor					
Managed Care and Commercial	43%	42%	39%	39%	38%
Medicare	43%	43%	44%	44%	46%
Medicaid	10%	12%	14%	14%	14%
Self-Pay & Other	4%	3%	3%	3%	2%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD September 30	
	2014	**2015**	**2016**	**2016**	**2017**
Payor					
Managed Care and Commercial	44%	42%	39%	42%	41%
Medicare	42%	43%	45%	43%	44%
Medicaid	10%	12%	13%	12%	13%
Self-Pay & Other	4%	3%	3%	3%	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.

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 September 30	
	2014	**2015**	**2016**	**2016**	**2017**
External Grants Earned					
Federal Sources	$97,327	$103,022	$108,253	$83,373	$87,143
Non-Federal Sources	88,284	81,796	87,883	64,744	69,734
Total	185,611	184,818	196,136	148,117	156,877
Internal Support	66,758	63,240	59,326	45,574	43,749
Total Sources of Support	$252,369	$248,058	$255,462	$193,691	$200,626

Key Ratios

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

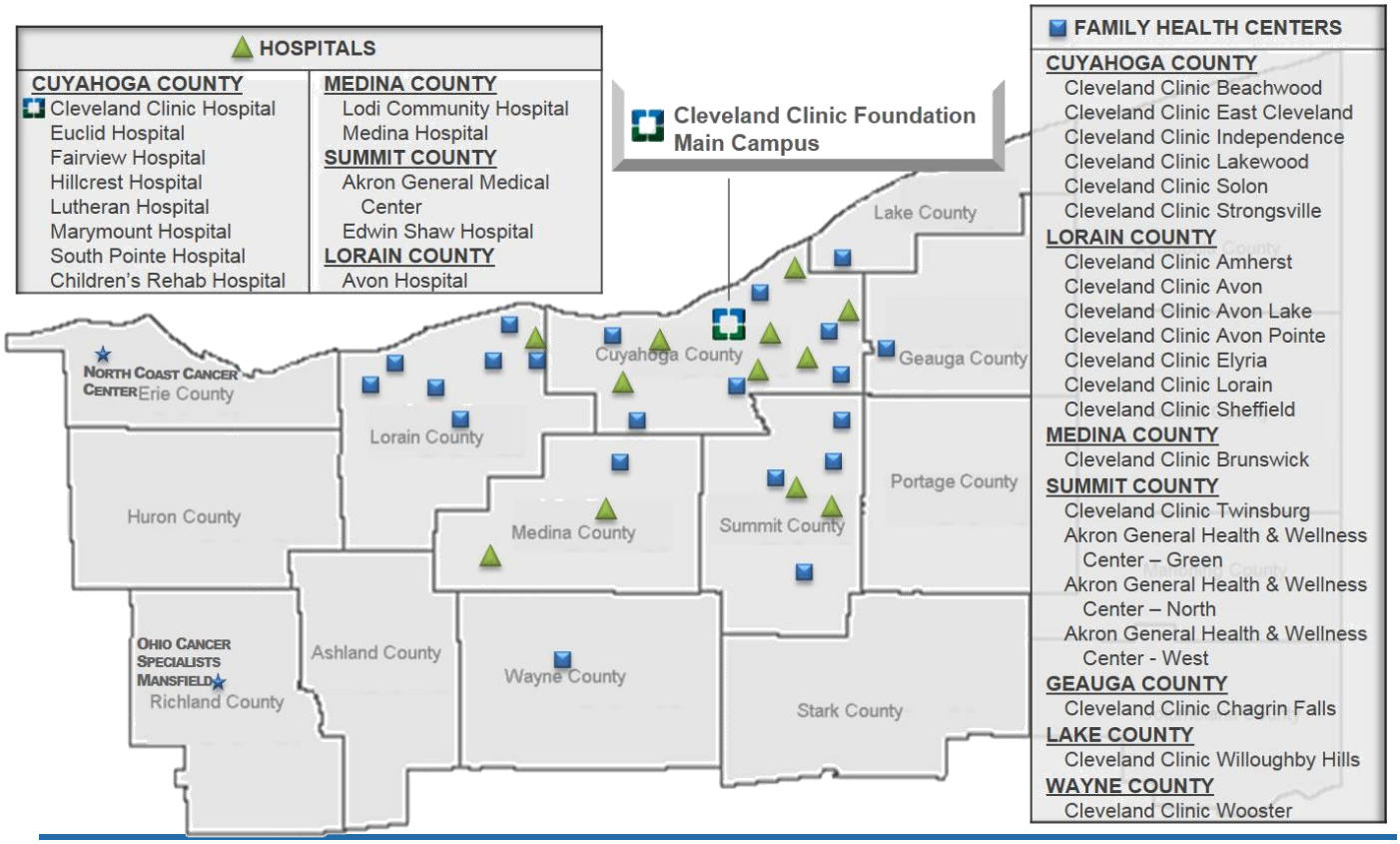
	Year Ended December 31			YTD September 30	
	2014	2015	2016	2016	2017
Liquidity ratios					
Days of cash on hand	377	347	349	340	377
Days of revenue in accounts receivable	47	47	51	54	47
Coverage ratios					
Cash to debt (%)	177.5	168.9	172.7	167.0	192.9
Maximum annual debt service coverage (x)	5.6	5.7	3.8	4.2	5.0
Interest expense coverage (x)	11.2	10.1	7.5	8.4	8.5
Debt to cash flow (x)	3.0	3.4	4.6	4.2	3.7
Leverage ratio					
Debt to capitalization (%)	36.1	36.5	36.4	36.8	33.4
Profitability ratios					
Operating margin (%)	7.0	6.7	3.0	1.8	3.7
Operating cash flow margin (%)	14.4	14.7	11.0	9.8	11.3
Excess margin (%)	10.2	8.5	6.2	6.4	12.2
Return on assets (%)	5.7	4.5	3.6	3.7	7.3

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

OVERVIEW

The Cleveland Clinic Health System (System) is a world-renowned provider of healthcare services and attracted patients from across the United States and from 185 other countries in 2016. As of September 30, 2017, the System operates 14 hospitals with approximately 3,900 staffed beds and is the leading provider of healthcare services in northeast Ohio. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates 21 outpatient Family Health Centers 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 250 staffed beds.

CLEVELAND CLINIC HEALTH SYSTEM – NORTHEAST OHIO SERVICE AREA AND FACILITIES



The following table sets forth the hospitals currently operated by the obligated issuers and their affiliates, together with each hospital's staffed bed count as of September 30, 2017:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,275
Avon Hospital[(1)]	126
Euclid Hospital	197
Fairview Hospital	460
Hillcrest Hospital	440
Lutheran Hospital	194
Marymount Hospital	275
Medina Hospital	118
South Pointe Hospital	173
Weston Hospital	155
	3,413
NON-OBLIGATED	
Akron General Medical Center	450
Children's Rehab Hospital	25
Edwin Shaw Rehabilitation Institute	35
Lodi Hospital	20
	530
HEALTH SYSTEM	3,943

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

AWARDS & RECOGNITION

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

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

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

In 2017, the Clinic was named one of the World's Most Ethical Companies by the Ethisphere Institute for the fifth consecutive year. Ethisphere Institute is a global leader in defining and advancing the standards of ethical business practices. The award recognizes organizations that promote ethical business standards and practices internally, enable managers and employees to make good choices and shape future industry standards by introducing best practices. Companies were evaluated in five categories: ethics and compliance programs; corporate citizenship and responsibility; culture of ethics; governance; and leadership, innovation and reputation.

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

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

The Clinic was recognized by Becker's Hospital Review on its list of 100 great hospitals in America. The Becker's Hospital Review editorial team selected hospitals for inclusion based on analysis of several ranking and award agencies, including U.S. News and World Report's 2016-17 Honor Roll and specialty rankings, Centers for Medicare and Medicaid Services star ratings, Leapfrog grades, Truven Health Analytics top hospitals, Most Wired hospitals and Magnet accreditation. According to the Becker's Hospital Review website, hospitals on this list are industry leaders in innovation, quality patient care and clinical research and have received recognition across various publications and accrediting organizations.

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

The System was recognized by Fortune and Great Place to Work on its list of Best Workplaces in Healthcare. The System ranked 17th on the list, which was compiled based on a random sample of approximately 88,000 employees in healthcare organizations. Companies were evaluated on their organizations' leadership strength and integrity, pride in their work and organization, and the quality of relationships with co-workers. The leading healthcare workplaces outperformed their peers in a number of important areas, such as training, compensation, clear expectations from management and the emotional health of their workplaces.

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

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

In October 2017, the Clinic and Marymount Hospital were included on a list of 60 of the greenest Hospitals in America compiled by *Becker's Hospital Review*. The list recognizes hospitals for their leadership in sustainability and energy management. A number of factors were considered for the recognition, including sustainability efforts, commitment to the Healthier Hospitals Initiative and awards received from the Environmental Protection Agency, U.S. Green Building Council and Practice Greenhealth.

FINANCING DEVELOPMENTS

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

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

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

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

Euclid Medical Office
Euclid, Ohio

CORPORATE GOVERNANCE

The Board of Directors of the Clinic is responsible for all of its operations and affairs and controls its property. The Board of Directors is also responsible for ensuring that the Clinic is organized, and at all times operated, consistent with its charitable mission and its status as an Ohio nonprofit corporation and tax-exempt charitable organization. The Board of Directors generally meets eight times per year, including an annual meeting during which the Clinic's officers are elected and standing committees are appointed. The size of the Board of Directors can range between 15 to 25 Directors (currently there are 23 Directors). The Board of Trustees serves as an advisor to the Board of Directors. The Trustees actively serve on the committees of the Board of Directors. At present, there are 73 active Trustees and 12 Emeritus Trustees (not including Directors). Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

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

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

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

In 2017, the responsibilities of the presidents of the System's acute-care hub hospitals — Hillcrest, Fairview and Akron — were expanded as they were appointed presidents of the East, West and South regions, respectively. The three regional presidents are responsible for

operations in all facilities (hospitals and family health centers) in their region. They are charged with the coordination and alignment of facilities and clinical programs. This structure allows all inpatient and outpatient services that are needed by the communities served to be available in each region. Each regional hospital has a president, and all hospital presidents report to J. Stephen Jones, MD, President of Regional Hospitals and Family Health Centers.

In May 2017, Toby Cosgrove, MD, President and Chief Executive Officer (CEO) of the Clinic, announced that he will transition out of the top executive role later this year. In September 2017, the Clinic's Board of Directors and Board of Governors unanimously selected Dr. Tomislav Mihaljevic based on the unanimous recommendation of a nomination committee that conducted an extensive review of potential successors. Refer to "APPOINTMENTS" for a description of Dr. Mihaljevic's background and experience. Drs. Cosgrove and Mihaljevic will work on a transition process together through the end of the year. Effective on or about January 1, 2018, Dr. Mihaljevic will assume the full duties of president and CEO, while Dr. Cosgrove will move to an advisory role to be determined by the Board of Directors and Dr. Mihaljevic. Before becoming CEO in 2004, Dr. Cosgrove was a cardiac surgeon for nearly 30 years, performing 22,000 operations and earning an international reputation for expertise in valve repair. As President and CEO, Dr. Cosgrove has driven major initiatives that have gained international recognition, created best practices in healthcare, focused on patient outcomes and promoted patient experience.

Twinsburg Family Health Center
Twinsburg, Ohio

APPOINTMENTS

Tomislav "Tom" Mihaljevic, MD has been appointed Chief Executive Officer and President of the Cleveland Clinic, effective on or about January 1, 2018. Dr. Mihaljevic joined the Clinic in 2004 as a cardiothoracic surgeon specializing in minimally invasive and robotically assisted cardiac surgeries. Since 2015, Dr. Mihaljevic has 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. 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. A search is underway to find his successor as Cleveland Clinic Abu Dhabi CEO.

Margaret McKenzie, MD has been appointed President of South Pointe Hospital. Dr. McKenzie succeeds Robert Juhasz, DO, who returned to full-time clinical practice within the organization. Dr. McKenzie joined the Clinic in 1995 and has most recently served as section head of General Obstetrics and Gynecology. Dr. McKenzie helped orchestrate the development of the Physician Diversity Scholars Program for Ohio University's Heritage College of Osteopathic Medicine at South Pointe Hospital and is an assistant professor of surgery at the Cleveland Clinic Lerner College of Medicine. She has co-authored two books and has written several articles in peer-reviewed journals.

Amy Merlino, MD, has been appointed Enterprise Clinical Medical Information Officer in the Information Technology Division. An obstetrics physician who specializes in maternal-fetal medicine, Dr. Merlino has been a leader in informatics since joining the staff in 2010. In her new position, Dr. Merlino will work with organizational and clinical business partners to optimize investment in technology and understand how technology impacts clinical care.

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

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

Edward Marx has been appointed Chief Information Officer, effective September 1, 2017. In this role, Mr. Marx leads the System's information technology strategy, working with clinical partners and caregivers across the System to enhance patient care through innovative technologies. Mr. Marx most recently served as Executive Vice President at the Advisory Board Company, where he provided information technology leadership and strategy to hospitals in New York City.

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

Medina General Hospital
Medina, Ohio

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 17 years for the creation of a new health and wellness community foundation to be used to address community health and wellness needs in the City of Lakewood. In addition, the Clinic will construct, own and operate an approximately 62,000-square-foot family health center expected to open in 2018 that will be located adjacent to the current site of the hospital. LHA ceased inpatient operations at the hospital in February 2016, while the current emergency department and several outpatient services at the hospital will continue until the opening of the new family health center and emergency department. The Lakewood Hospital site is currently leased by LHA from the City of Lakewood, and clinical services at that location are operated by the Clinic since the cessation of inpatient operations. The lease has been amended and is expected to terminate approximately thirty to sixty days after the opening of the family health center and emergency department.

Prior to the signing of the agreement, a lawsuit was filed against the Clinic, LHA, the City of Lakewood and others (Defendants) by a few Lakewood residents (Plaintiffs) seeking to stop the closure of the hospital and money damages. The lawsuit was dismissed on July 10, 2017 but was appealed, and the appeal is pending. In November 2015, Lakewood voters defeated a proposed charter amendment that would have required voter approval on any Lakewood City Council ordinance that would have caused the hospital to no longer be a full time and full service hospital. As a result of duly signed petitions, a referendum vote to repeal the ordinance occurred in November 2016. The results upheld the ordinance adopted by Lakewood City Council.

EXPANSION AND IMPROVEMENT PROJECTS

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

In November 2016, the System opened Avon Hospital (named "The Roseann Park Family Tower"), a new hospital located adjacent to the existing Family Health Center in Avon. Avon Hospital is an approximately 221,500 square foot five-story facility with capacity for 126 beds. The facility includes an intensive care unit, a cardiac catheterization lab, and expanded surgical and emergency services. It was designed to leverage the latest in wireless capabilities and serve as a test site for evaluating future advancements in patient care. The cost of the new facility was approximately $160 million, and construction took over two years to complete.

In March 2017, the System opened the Taussig Cancer Center, a new cancer outpatient building, on the Clinic's main campus that unites

multidisciplinary surgical, medical, and support services of the Cleveland Clinic Taussig Cancer Institute in one facility. The new building is adjacent to the Crile Outpatient Building and across from the Tomsich Pathology Laboratories Building. The 377,000 square foot, seven-story building houses 126 exam rooms, 98 infusion bays, 6 linear accelerators, 7 procedure rooms, a Gamma Knife suite and other cancer support functions. The building was designed to improve the patient experience by allowing natural light in the infusion bays and other treatment areas and helping patients receive treatment more quickly, efficiently and effectively. The cost of the new building was approximately $276 million, and construction took over two years to complete.

With the anticipated increase in patient services provided by the new cancer outpatient building, the System opened a 3,000 space structured parking garage in November 2016 located on the southeast corner of the main campus. The garage is exclusively for employees, allowing current employee parking to be designated for patients and visitors. A pedestrian bridge will connect the garage to the Clinic's facilities. The garage and connecting bridge are expected to cost approximately $49 million. The pedestrian bridge is expected to be completed in the fourth quarter of 2017.

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

Radiology Master Plan - This multi-year, five-phase renovation and construction plan is aimed at fulfilling the growth needs of the Department of Radiology within the Imaging Institute. The project will consolidate and centralize magnetic resonance (MR) services for the Clinic in the Glickman Tower located on the Clinic's main campus. The project also includes the renovation of vacated molecular functional imaging space into a new Computed Tomography (CT) department including sub-waiting, prep, changing, and hydration. Additionally, the plan allows for a new outpatient entrance to the Department of Radiology and enhanced patient waiting and changing areas. Phase 1A of the project, the Interventional MR Surgical Suite, began in 2009 and was completed in 2010. The Suite combines high-field MR imaging with a surgical suite, which allows surgeons to take advantage of MR imaging in real time during surgical procedures. Phase 1B, the consolidation of MR services in the Glickman Tower, began in the fourth quarter 2010 and was completed in July 2011. Phase 2, the consolidation of CT services, was completed in the third quarter of 2013. Phase 3, the relocation and upgrade of the Interventional Radiology Department, began in the third quarter of 2013 and was completed in the first quarter of 2015. Phase 4 began in the fourth quarter of 2015, and phase 5 began in the fourth quarter of 2016. These phases include thirty hard-walled and ten curtained holding rooms, a preparation and recovery area with 20 bed spaces that opened in 2016, a newly renovated ultrasound department that includes adult and pediatric scanning that also opened in 2016, a state of the art myelogram room, gastrointestinal department and general diagnostic departments with sub-waiting and changing areas. The entire project is expected to be completed in 2018 with a total estimated cost of approximately $86 million.

Enterprise Administrative Patient Management - The System is currently in the midst of a multi-year project to align revenue cycle support services and processes to support patients as they progress through their continuum of care. The Enterprise Administrative

Patient Management (EAPM) project will consolidate thirteen different technology systems used for scheduling appointments, admissions, electronic medical records, billing and collections into one technology platform with the goal of improving patient experiences. Reducing the number of systems is expected to improve patient service and employee efficiency. Implementation of EAPM began in the first quarter of 2012 at the System facilities in Weston, Florida. The Clinic's main campus and family health centers implemented EAPM in the first quarter of 2016. Marymount and Medina Hospitals implemented EAPM in the second quarter of 2017, and Akron General Medical Center and Lodi Hospital implemented EAPM in the third quarter of 2017. Implementation for the other System hospitals is planned in phases over the next few years. 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 late 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 second quarter of 2018 with a total estimated cost of $32 million. The joint venture obtained a loan for the majority of the construction costs. Cleveland Clinic Florida will lease the facility upon completion of construction.

Akron General Emergency Department – In 2015, Akron General Medical Center began site preparations for a two-story, 73,000 square foot emergency department that will triple the size of the current space. The first floor will house the emergency department, and the second floor will contain administrative offices and a clinical decision unit for patients that need short-term observation care. The facility will have eight triage rooms and 39 treatment rooms for patients, including six high-acuity trauma rooms, an area designated for patients seeking treatment for sexual assault, an expanded behavioral health unit, an imaging department, a separate urgent care area, and an area for quarantining and treating highly contagious patients. The facility is expected to cost approximately $55 million. Construction of the building began in the first quarter of 2017, and the emergency department is expected to be completed in third quarter of 2018. The clinic decision unit

on the second floor of the facility is expected to have capacity for up to 18 short-term observation patient beds and is scheduled to open in the fourth quarter of 2018.

Lakewood Family Health Center – In January 2016, the Clinic started design of a new approximately 62,000 square foot, three story family health center in Lakewood on a site adjacent to the recently closed Lakewood Hospital. The facility will have an emergency department located on the first floor with 16 treatment rooms. On the second and third floors, the facility will have 60 exam rooms. There will also be lab and imaging services to support operations at the facility. The facility is projected to cost approximately $34 million and is scheduled to open in the third quarter of 2018.

Health Education Campus - In 2013, the Clinic and Case Western Reserve University (CWRU) School of Medicine reached an agreement to build a health education campus that will contain CWRU's medical school program and the Cleveland Clinic Lerner College of Medicine. The campus includes a facility that will be located on the Clinic's main campus and will serve as home for the seminar, lecture, and laboratory curriculum taught during the first two years of medical school. Students' clinical training will continue to take place at area hospitals. This initiative is aligned with the future plans of the Clinic's main campus and supports the Clinic's mission and strategic direction. The facility will also house the CWRU Nursing School and School of Dental Medicine. The facility is designed to encourage extensive interaction and collaboration among the professions. Construction of the facility broke ground on October 1, 2015 and is expected to take approximately four years to complete. CWRU and the Clinic will share in the construction costs of approximately $453 million and the ongoing operational costs of the facility, with a portion of the construction costs expected to be raised through fundraising efforts and donations. Plans also include a separate dental clinic that will be adjacent to the medical school facility and will cost approximately $61 million. The dental clinic will provide a space where students can treat patients under dental faculty supervision. Construction of the dental clinic broke ground in October 2017, and the facility is expected to open at the same time as the medical school.

Cleveland Clinic Children's – In early 2017, the Clinic started a transformation of the former Taussig Cancer Building on the Clinic's main campus into a 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, playroom, pediatric and family friendly café and 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 will have 60 exam rooms, 20 infusion rooms, and four procedure rooms. Outpatient services will include audiology, behavioral health, cardiology, endocrinology/diabetes, gastroenterology, hematology/oncology, infectious disease, neurology, nutrition, primary care and pulmonology. The renovation project including building infrastructure upgrades is projected to cost approximately $36 million and is scheduled to open in the third quarter of 2018.

PHILANTHROPY CAMPAIGN

The Clinic publicly launched "The Power of Every One" philanthropic campaign in June 2014 with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the Clinic to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. As of September 30, 2017, the Clinic has received pledges, cash and other assets of approximately $1.2 billion toward the goal.

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

INNOVATIONS

Cleveland Clinic Innovations promotes scientific, clinical and administrative creativity throughout the System and seeks commercial application of the products of that creativity. Specifically, it helps to grow the Clinic's innovative capacity, mentors inventors, licenses technology, secures resources, and establishes spin-off companies and strategic collaborations with corporate partners. Since 2000, Cleveland Clinic Innovations has launched 80 companies, transacted more than 520 technology licenses, filed over 3,800 patent applications with over 1,300 issued patents, and acted on approximately 3,600 new inventions.

Cleveland Clinic Innovations operates a 50,000-square-foot Global Cardiovascular Innovation Center (GCIC) on the Clinic's main campus, which is home to its operations, as well as an incubator facility for approximately 30 companies. GCIC celebrated its tenth anniversary in February 2017 and has supported the development of over 50 technologies and the creation of over 1,000 new jobs.

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 September 2017, Cleveland Clinic Innovations agreed in principal

to partner with a Silicon Valley startup accelerator that is opening a location in Cleveland. The Clinic and JumpStart Inc. are teaming up with Plug and Play, the largest accelerator program in the world, in a three-year partnership that will enable the trio to work together in the hopes of attracting dozens of U.S. and international health care startups to Cleveland every year. The partnership is expected to operate two cohort programs annually, inviting a group of at least ten companies every six months.

In late 2015, the Clinic created the Cleveland Clinic Ventures department, which operates in tandem with Cleveland Clinic Innovations to turn medical breakthrough inventions into products and companies. The strategy of Cleveland Clinic Ventures will be 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. The collaboration between departments is expected to increase the Clinic's commercialization impact and advance technologies to improve patient care.

ImageIQ, an imaging contract research organization specializing in advanced medical image acquisition, analysis and visualization that was spun out of Cleveland Clinic Innovations in 2011, was acquired by ERT in 2017. ERT is a global data and technology company that minimizes uncertainty and risk in clinical trials. The acquisition enables ERT to offer advanced clinical trial imaging analysis using cloud-based technology that delivers compliant data for use in clinical development with more accurate and verifiable imaging results than subjective readings commonly relied upon with standard scoring systems.

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 fund 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. The GATE™ tricuspid AVS has been developed and manufactured by NaviGate, which licensed the seminal technology from the Clinic. In June 2017, Samir Kapadia, MD, of the Heart and Vascular Institute successfully completed the two First-in-Man studies in Germany for his novel trans-septal puncture device for structural heart therapies in the left atrium.

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 15th Annual Medical Innovation Summit occurred on October 23-25, 2017 and focused on investable technologies related to genomics and precision medicine. Speakers included executives from AstraZeneca, Pfizer, Boston Scientific, Stryker, and Human Longevity, as well as Dr. David Shulkin, the Secretary of Veterans Affairs. The Summit also unveiled the Top 10 Medical Innovations of 2018 as selected by a distinguished panel of Clinic doctors and researchers, which highlighted the potential for medical breakthroughs in the coming year.

CLINICAL AFFILIATIONS

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

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

JOINT VENTURES

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

Select Medical is one of the nation's largest providers of post-acute care services and has partnerships with academic medical centers around the country. The Clinic is a minority member in the joint venture.

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

MEDICAID MANAGED CARE

In August 2017, Molina Healthcare of Ohio and the Clinic announced that Molina will include the Clinic in its Medicaid network effective August 1, 2017. This is the first time the Clinic and Molina Healthcare of Ohio have contracted for Medicaid coverage. The new

relationship allows Molina to provide its Medicaid customers with additional options to access patient care at the Clinic.

In November 2017, CareSource and the Clinic signed a long-term contract solidifying that CareSource Medicaid and MyCare members can continue to have their care covered at Cleveland Clinic without any interruption. CareSource previously sent the Clinic a notice of termination of its managed care contract in May 2017. CareSource is the largest of five providers of Medicaid managed care plans in Ohio and accounted for approximately 66% of the Medicaid net patient service revenue of the System (or approximately 5% of net patient service revenue of the System) for the year ended December 31, 2016.

ACCOUNTABLE CARE ORGANIZATION

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

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 in northeast Ohio. Pending regulatory approvals, the new Cleveland Clinic Oscar individual health plans will be available through the Ohio health insurance exchange or directly through Oscar Health. Enrollment in the plans is expected to be available in 2017, with coverage beginning on January 1, 2018. Plan participants will be matched with teams from both organizations that will work together across the continuum of care to ensure that participant's health and wellness needs are proactively met. Participants will have access to various technology to analyze and manage their health needs, including the option of telehealth virtual visits through Cleveland Clinic Express Care Online and Oscar's Virtual Visits.

In November 2017, Humana Inc., a leading health and well-being company, and the Clinic announced the creation of two new $0 premium Medicare Advantage health plans. The Humana Cleveland Clinic Preferred Medicare Plans will offer patient-centered, affordable access to

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

AKRON GENERAL HEALTH SYSTEM

In November 2015, the Clinic became the sole member of Akron General Health System (Akron General), an integrated healthcare delivery system with a 532-registered bed flagship medical center located in Akron, Ohio. In addition to the flagship medical center, Akron General also includes Lodi Community Hospital, Edwin Shaw Rehabilitation Institute, 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 have committed to additional funding for the capital expenditure needs to support Akron General's capital plan for at least the first five years after the member substitution. Initiatives include a new emergency department at Akron General Medical Center that started construction in the first quarter of 2017, two new outpatient centers in the surrounding Akron area and replacement of Akron General's electronic medical records system to enhance safety, quality, and patient experience and reduce the overall cost of care.

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

Although corrective actions have been taken by Akron General related to all of the physician arrangements at issue, and the Clinic has implemented its compliance programs at Akron General, there is a probable liability associated with the matters described above. Preliminary discussions with the DOJ and related government authorities about the physician arrangements are ongoing, and thus neither a timeframe for completion of the inquiry by the government authorities nor the amount of 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. Because it is not possible to estimate the amount of any fines, penalties and other potential liability thereunder at this time, no provision related to such items has been recognized in the consolidated financial statements of the System. 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 May 2017, the Clinic and Union Hospital, located in Dover, Ohio, signed a non-binding letter of intent for the Clinic to become the sole corporate member of Union Hospital. Both organizations are working to finalize due diligence and negotiation of a definitive agreement and then will seek regulatory approvals for Union Hospital to become part of the System. Union Hospital has more than 100 patient beds, 300 healthcare providers on staff, and 1,100 employees. It also has several off-campus satellite services and operates a hospital-owned physician network with numerous offices and approximately 20 providers. The Clinic has maintained an existing relationship for the past several years with Union Hospital through the Telestroke Network, which connects patients to the Clinic's Cerebrovascular Center.

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 Clinic 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 open in 2020. The facility was fully vacated in the first quarter of 2017.

In addition to the London project, the System operates health and wellness centers in Toronto, Canada, including a sports medicine clinic that was acquired in the fourth quarter of 2017, and provides management services to Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that opened in March 2015 and currently has approximately 250 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 Health System's healthcare operations while promoting the Cleveland 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. Maximizing attributed lives where patients bring an entirely new level of consumerism is of paramount importance in this emerging environment. The System is well engaged in this shift with nearly 500,000 lives from Northeast Ohio and Florida under some form of risk-based contract in 2017. This dynamic landscape has and continues to influence how the System shapes its path forward.

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 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 who are relevant to the changing environment
- Leverage and extend the unique assets and capabilities of the System to grow and diversify the revenue base and to solidify connectivity with other referral sources

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 and innovation

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.

Efforts to transform care continue to constitute a major focus for the enterprise. Included among the activities within and across the clinical institutes are improvements in high reliability, access, care path development and implementation, and caregiver engagement. Of particular note is the initiative to build a focused business unit within the System for population management. This unit will be geared to ensure success in managing value-based contracts.

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 2016, management estimates that Care Affordability initiatives and other localized efforts enabled $634 million of expense reductions. 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 year over year.

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.

Leadership also is executing a focused growth strategy, domestically and internationally. A major emphasis of the domestic agenda is to assemble a distributed and rational network to execute against the payor strategy. Meanwhile, leadership continues to execute its international strategy to extend its unique model and capabilities more broadly and to meet its organizational goals. The Clinic also is engaged with a variety of non-provider entities to establish relationships that will enhance its strategic initiatives.

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, how care is organized and delivered, how research and education are effectuated, and how the organization's value is conveyed 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

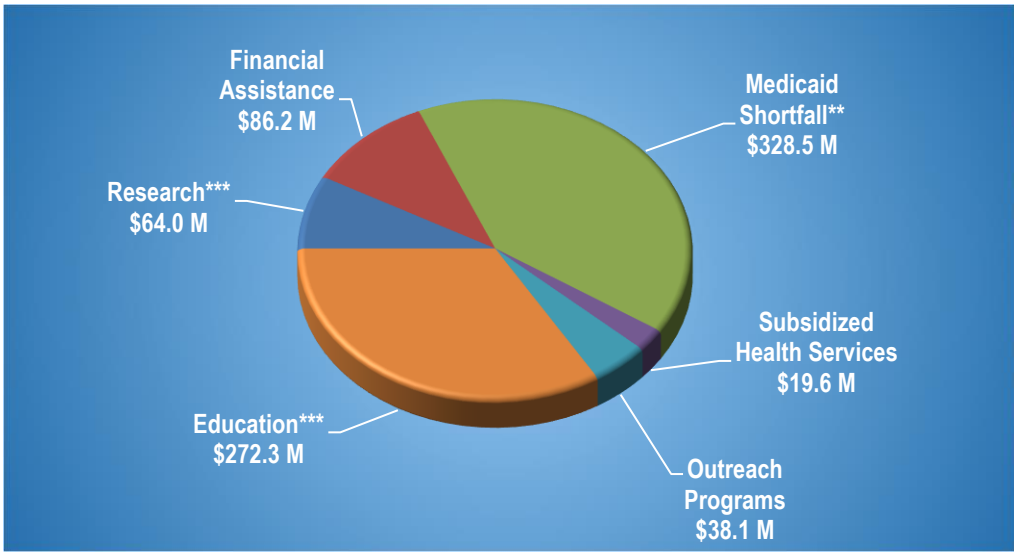
Community Benefit

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. 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, which requires individuals to obtain healthcare insurance, nonprofit hospitals across the United States saw an increase of individuals covered by Medicaid or health exchange policies. With more persons covered under such programs, there was a decline in the number of patients seeking financial assistance.

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

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

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 2016 CHNA needs identified throughout the System include:

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

Hospital implementation strategies that address the health needs identified in the assessments have been developed by individual hospital leadership teams. The Implementation Strategy Reports have been added to the Clinic's website in compliance with the regulatory requirements. The CHNA reports and implementation strategies for the System hospitals are available on the Clinic's website (www.clevelandclinic.org/CHNAReports).

Economic Impact

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

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

SUSTAINABILITY

The System supports healthy environments for healthy communities, recognizes the link between environmental and human health and strives to responsibly address and mitigate its environmental impacts. As a national leader in healthcare, the System is in a position to lead by example in the adoption of environmental best practices. With a built environment portfolio of more than 22 million square feet and more than 51,000 caregivers, the impact of the System on the community and ecosystem, both positive and negative, is substantial.

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

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

The Clinic is a member of Practice Greenhealth , the nation's leading health care community that empowers its members to increase their efficiencies and environmental stewardship while

improving patient safety and care through tools, best practices and knowledge. In 2017, the Clinic was awarded the prestigious "Greening the OR" environmental achievement award offered by Practice Greenhealth for the second year in a row. This award is given to only one healthcare system in the country for its performance in energy efficiency, materials efficiency and recycling in the operating room. The Clinic also won the Top 25 Environmental Excellence Award for Best of Sustainability in Health Care. The Top 25 Environmental Excellence Awards recognize health care facilities that exemplify environmental excellence and are setting the highest standards for environmental practices in health care. Award winners are chosen from hospitals that have the highest scores using Practice Greenhealth's thorough scoring and evaluation system. The System was honored with thirty additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in health care sustainability.

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

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

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

DIVERSITY

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

externally focused pipeline development programs.

The System was awarded the American Hospital Association's Equity of Care Award for 2016. Presented annually, this recognition honors hospital systems that have achieved a high level of success in reducing healthcare disparities while promoting diversity throughout the organization. In 2017, the System was ranked number five on the list of the country's top twelve healthcare organizations for diversity management practices by DiversityInc. The System has made this list for the eighth consecutive year. Rankings are empirically driven and assess performance based on a number of factors including CEO commitment, equitable talent development, talent pipeline and supplier diversity. Additionally, the Clinic was recognized as a "2017 Leader in LGBTQ Healthcare Equality," by the Human Rights Campaign. This distinction was received by meeting criteria for non-discrimination in 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.

HEALTH INFORMATION TECHNOLOGY

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

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

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

The System participates in the Care Everywhere network, a module offered through Epic Systems Corp. that allows health systems to safely and directly share electronic medical records (EMRs). Through this program, the System has access to hundreds of healthcare organizations nationwide. The System has exchanged over 6 million patient records with more than 870 hospitals, 1,090 emergency rooms, and 24,000 clinics to assist with treating patients in all fifty

states across the country since the beginning of 2015. This is believed to have improved patient care by immediately providing more complete medical histories, eliminating the need for unnecessary diagnostic tests, allowing for faster and more accurate diagnosis and aiding in criteria required for Stage 2 meaningful use standards. The System collaborates with both local and national hospitals and health systems to link EMRs via Epic. Since 2013, the System engaged with ClinicSync, Ohio's statewide electronic medical records exchange. Participation in CliniSync links the System to a significant number of hospitals and physician practices across Ohio.

To further broaden its interoperability capabilities, the System has also engaged with Surescripts, a health information service provider that connects the System to over 250,000 providers across the nation via DIRECT messaging. The System is also connected to eHealth Exchange, the national health exchange hub. This connection was implemented in the summer of 2014 and has allowed the System to exchange data with the Social Security Administration.

In 2015, the System connected its electronic medical system, MyPractice, to the Veterans' Administration (VA) electronic medical record system. The connection to the VA has had over 30,000 exchanges since implementation. This data exchange allows medical information of veteran patients to be securely shared and improves provider-to-provider communication between the Clinic and the VA.

CONFLICT OF INTEREST

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

An initiative to bring transparency to the System's relationships with industry was implemented in 2008, in which the specific types of interactions that individual physicians and scientists have with industry were disclosed on publicly-accessible web pages on the System's internet site. Information can be accessed by

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

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

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

ENTERPRISE RISK MANAGEMENT

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

In the ERM process, risk identification is conducted resulting in a System risk profile that categorizes individual risks based on their impact upon the System's ability to meet its strategic objectives. During this process, certain risks are identified as top risks and then further separated into sub-risks and individual risk components. Extensive risk assessments and mitigation analysis are prepared during this process whereby risk components are evaluated

according to their likelihood of occurring and potential impact should they occur. Risk mitigation activities, including risk response effectiveness, are examined, reviewed and updated as part of this evaluation. The most recent comprehensive evaluation of top risks was concluded in the third quarter of 2016. ERM is an on-going program, with regular reporting to senior management, including the Audit Committee of the Board of Directors, the body with oversight responsibility for ERM.

INTERNAL CONTROL OVER FINANCIAL REPORTING

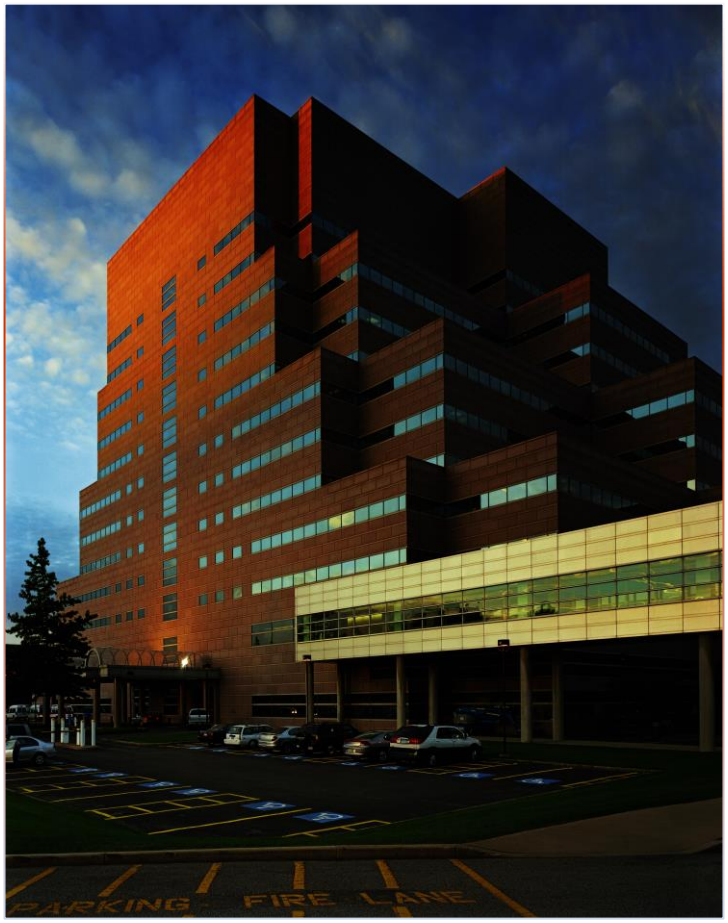
The System regularly evaluates its internal control environment over the System's financial reporting processes through an initiative based upon concepts established in the Sarbanes-Oxley Act of 2002. The goals of the initiative are to ensure the integrity and reliability of financial information, strengthen internal control in the reporting process, reduce the risk of fraud and improve efficiencies in the financial reporting process. The initiative reviews all aspects of the financial reporting process, identifies potential risks and ensures that they have been mitigated utilizing a management self-assessment process. As a result of this initiative, management of the System issued a report on the effectiveness of its internal control over financial reporting as part of the issuance of its consolidated financial results for 2016, which is the eighth 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 control over financial reporting during the nine months ended September 30, 2017 that have materially affected, or are likely to materially affect, the internal control over financial reporting for the System.

INDUSTRY OUTLOOK

In December 2016, Moody's Investor Services (Moody's) maintained its stable outlook for the U.S. not-for-profit healthcare sector, an outlook Moody's revised from negative to stable in August 2015. Moody's expects operating cash flow growth of 0%-1% and patient volume growth of about 1%, which will help offset pressure from rising drug costs, pension liabilities and employment expenses. Hospitals are also experiencing rising co-pays and deductibles in employee health plans that is increasing bad debt. Moody's also notes that hospital mergers, acquisitions and affiliations will remain prevalent and can drive volume growth.

In May 2017, Moody's compiled preliminary financial data that showed that U.S. nonprofit hospitals' median operating margin fell in fiscal year 2016 as expenses grew. Moody's is attributing the decline in profitability to lower reimbursement and rising expenses.

In January 2017, Standard & Poor's (S&P) maintained its stable outlook for the U.S. not-for-profit healthcare sector, despite seeing a sharp rise in legislative risk due to the potential repeal of the Affordable Care Act and related consequences as well as other aspects of the health care delivery system. S&P revised its



Crile Building
Cleveland, Ohio

outlook from negative to stable in September 2015. S&P indicated that 2015 financial medians and 2016 ratings and outlook experience continue to support their outlook for sector stability.

The System continues to be impacted by industry challenges that put pressure on the System's financial performance. Management is focused on the recruitment and retention of qualified staff in many clinical areas in order to meet the demands of patient activity, particularly as the Affordable Care Act health insurance mandates and Medicaid expansion programs have been implemented that have increased the number of insured Americans seeking healthcare services. These efforts pressure the System's salary cost structure, as well as employee benefit costs. Pharmaceutical costs and medical supply costs continue to create challenges to the cost structure. Increases in pharmaceutical costs are driven by utilization, price increases and the specialized nature of many pharmaceuticals used in oncology and hematology. Medical supply costs are primarily driven by utilization and price of implants. For both pharmaceuticals and medical supplies, a sizeable percentage of the cost increase flows through to increases in payments from payors; however, the balance cannot be passed through to payors. Additionally, the healthcare industry is subject to significant regulation by federal, state, and local governmental agencies and independent organizations and accrediting bodies, changes in technology and treatment modes, competition and changes in third-party reimbursement programs. The decline in the population of the Greater Cleveland area, as noted in 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 September 30				For the nine months ended September 30			
	2017	2016	Variance	%	2017	2016	Variance	%
Inpatient admissions[(1)]								
Acute admissions	41,927	40,367	1,560	3.9%	127,631	122,123	5,508	4.5%
Post-acute admissions	2,927	3,082	-155	-5.0%	9,036	9,411	-375	-4.0%
	44,854	43,449	1,405	3.2%	136,667	131,534	5,133	3.9%
Patient days[(1)]								
Acute patient days	217,545	209,947	7,598	3.6%	660,426	635,947	24,479	3.8%
Post-acute patient days	24,046	26,036	-1,990	-7.6%	74,559	78,382	-3,823	-4.9%
	241,591	235,983	5,608	2.4%	734,985	714,329	20,656	2.9%
Surgical cases								
Inpatient	15,196	14,918	278	1.9%	46,355	45,015	1,340	3.0%
Outpatient	35,033	37,094	-2,061	-5.6%	110,145	110,831	-686	-0.6%
	50,229	52,012	-1,783	-3.4%	156,500	155,846	654	0.4%
Emergency department visits	162,318	166,983	-4,665	-2.8%	486,456	491,777	-5,321	-1.1%
Observations	14,379	15,183	-804	-5.3%	45,012	43,259	1,753	4.1%
Clinic outpatient evaluation and management visits	1,063,030	1,063,235	-205	0.0%	3,307,142	3,168,230	138,912	4.4%

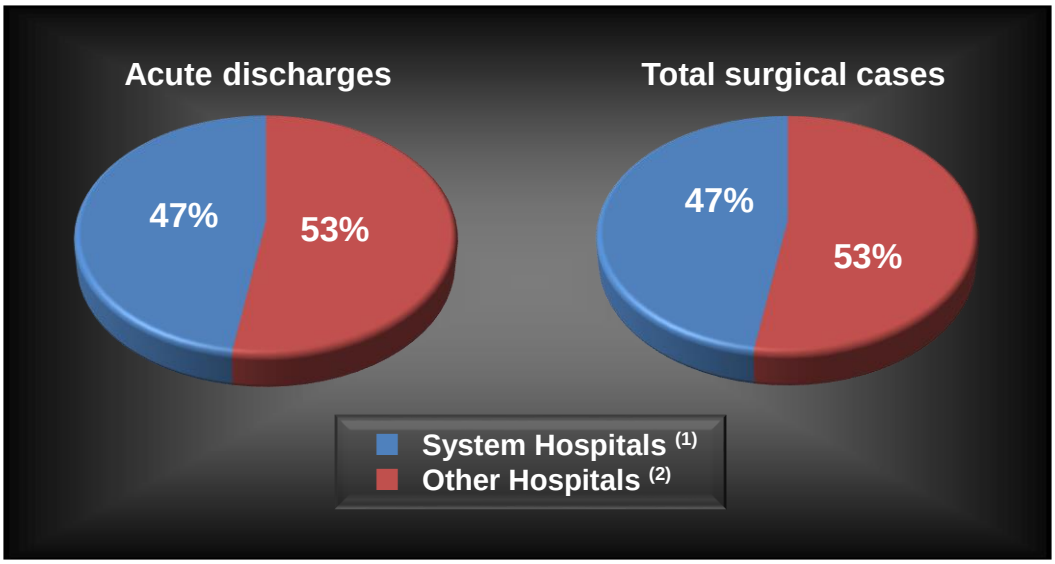
[(1)] Excludes newborns

Inpatient acute admissions for the System increased 4% in the third quarter of 2017 and 5% in the first nine months of 2017 compared to the same periods in 2016. In the first nine months of 2017, the Clinic experienced flat acute admissions, and the regional hospitals, which include Akron General, collectively experienced a 7% increase in acute admissions, which resulted in a 5% increase at the System's facilities in northeast Ohio. According to data from the Center for Health Affairs, acute discharges excluding newborns in the Northeast Ohio service area increased 1% in the first nine months of 2017 compared to the same period in 2016. The Florida facilities experienced a 3% increase in acute admissions over the same period.

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

According to data from the Center for Health Affairs, total surgical cases in northeast Ohio increased 3% in the first nine months of 2017 compared to the same period in 2016. The Florida facilities remained flat in total surgical cases over the same period. The surgical mix of total surgical cases for the System for the first nine months of 2017 was 30% inpatient and 70% outpatient, which represents an approximately 1% shift from outpatient to inpatient compared to the surgical mix in the first nine months of 2016.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the nine months ended September 30, 2017:



Source: The Center for Health Affairs Volume Statistics

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

LIQUIDITY

Cash and Investments

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

Investments are primarily maintained in a master trust fund administered using a bank as trustee. Effective April 1, 2017, the System completed the transition of the management of its investment portfolios from a third-party external advisor to the Cleveland Clinic Investment Office (the "CCIO"). These portfolios include the Cleveland Clinic's general long-term investment portfolio, its defined benefit pension fund and the captive insurance fund. Investment professionals in the CCIO are charged with the day-to-day management of these investments and their strategic direction. The System has established formal investment policies that support the System's investment objectives and provide an appropriate balance between return and risk.

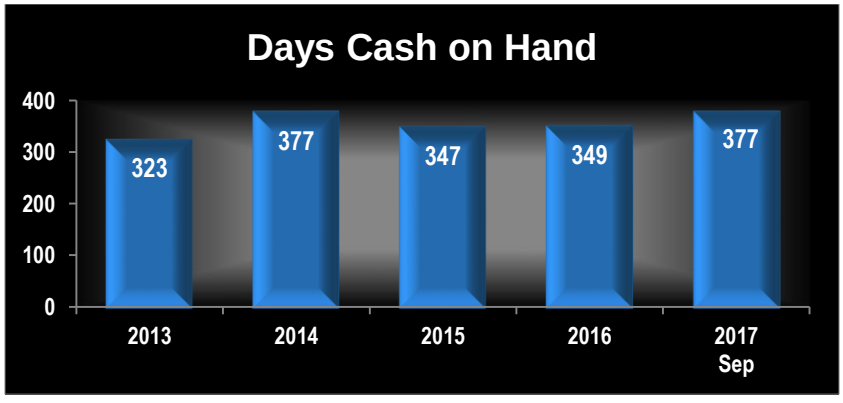
The following table sets forth the allocation of the System's cash and investments at September 30, 2017 and December 31, 2016:

Cash and Investments
(Dollars in thousands)

	September 30, 2017		December 31, 2016	
Cash and cash equivalents	$ 982,492	11%	$ 687,410	9%
Fixed income securities*	2,243,245	26%	2,109,524	27%
Marketable equity securities*	3,108,447	36%	2,785,380	35%
Alternative investments	2,399,528	27%	2,282,940	29%
Total cash and investments	$ 8,733,712	100%	$ 7,865,254	100%
Less restricted investments**	(959,860)		(868,367)	
Unrestricted cash and investments	$ 7,773,852		$ 6,996,887	
Days cash on hand	377		349	

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

The following chart summarizes days cash on hand for the System at December 31 for the last four years and at September 30, 2017:



At September 30, 2017, total cash and investments for the System (including restricted investments) were $8.7 billion, an increase of $868 million from $7.9 billion at December 31, 2016. Cash inflows consist of cash provided by operating activities and related investment income of $1,239 million and a net increase in restricted gifts and income of $120 million. Cash inflows were offset by net capital expenditures of $414 million and scheduled principal payments on debt of $78 million.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $195.7 million at September 30, 2017, with an asset mix of 7% cash and short-term investments, 45% fixed-income securities, 35% equity investments and 13% 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 September 30, 2017 are $84.1 million of funds held by trustees. Funds held by trustees primarily represents 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 September 30, 2017, 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 September 30, 2017 and December 31, 2016 consist of the following:

Alternative Investments
(Dollars in thousands)

	September 30, 2017		December 31, 2016	
Hedge funds	$ 1,136,517	48%	$ 1,134,136	50%
Private equity/venture capital	799,408	33%	696,786	30%
Real estate	463,603	19%	452,018	20%
Total alternative investments	$ 2,399,528	100%	$ 2,282,940	100%

Alternative investments have varying degrees of liquidity and are generally less liquid than the traditional equity and fixed income classes of investments. Over time, investors may earn a premium return in exchange for this lack of liquidity. Hedge funds typically contain redeemable interests and offer the most liquidity of the alternative investment classes. These investment funds permit holders periodic opportunities to redeem interests at frequencies that can range from daily to annually, subject to lock-up provisions that are generally imposed upon initial investment in the fund. It is common, however, that a small portion (5-10%) of withdrawal proceeds are held back from distribution pending the fund's annual audit, which can be up to a year away. Private equity, venture capital, and real estate funds typically have non-

redeemable partnership interests. Due to the inherent illiquidity of the underlying investments, the funds generally contain lock-up provisions that prohibit redemptions during the fund's life. Distributions from the funds are received as the underlying investments in the fund are liquidated. These investments have an initial subscription period, under which commitments are made to contribute a specified amount of capital as called for by the general partner of the fund. The System periodically reviews unfunded commitments to ensure adequate liquidity exists to fulfill anticipated contributions to alternative investments.

Investment Return

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

The System's long-term investment portfolio, which excludes assets held for self-insurance, reported investment gains of 2.9% for the third quarter of 2017, which is higher than the portfolio's benchmark gain of 2.7% and lower than investment gains of 3.1% experienced in the third quarter of 2016. For the first nine months of 2017, the System experienced investment gains of 9.3%, which is higher than the portfolio's benchmark gains of 8.7% and higher than the investment gains of 5.4% experienced for the first nine months of 2016.

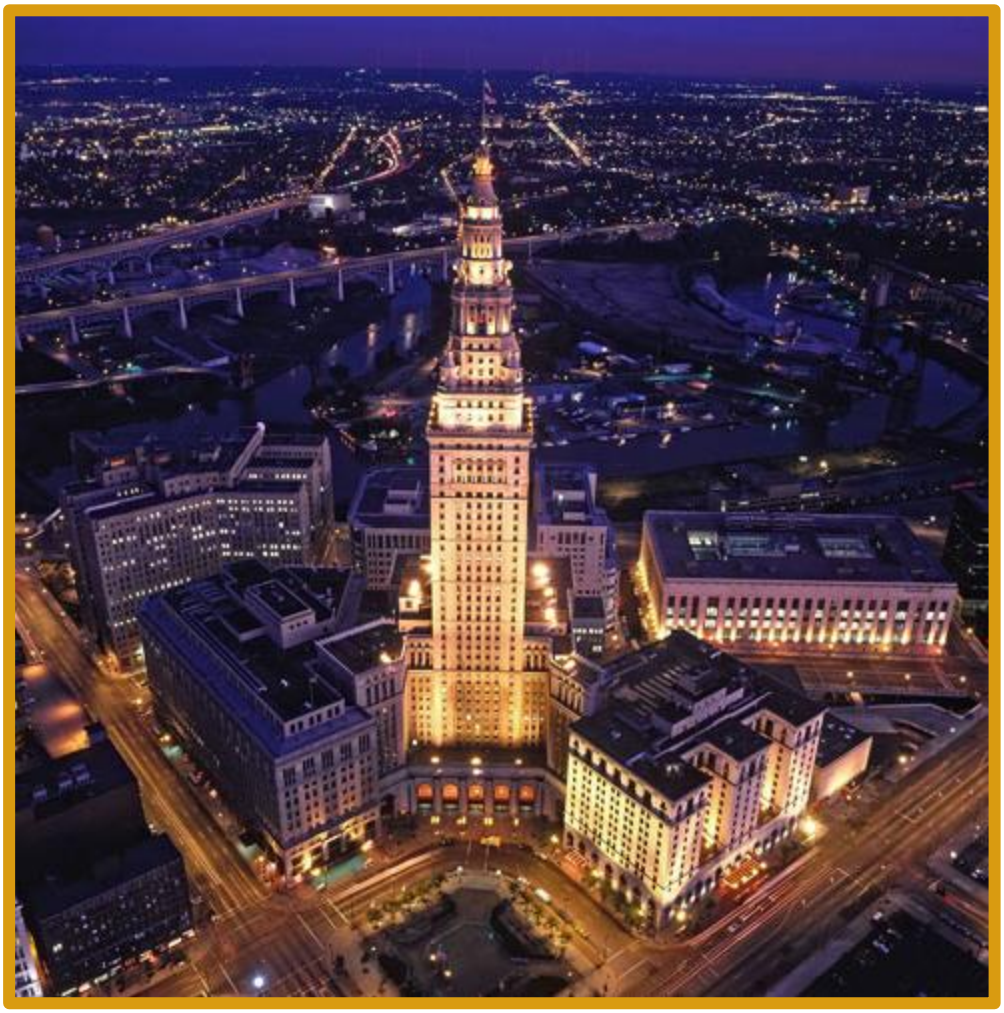
Total investment return for the System is comprised of the following:

Investment Return
(Dollars in thousands)

	For the quarter ended September 30		For the nine months Ended September 30	
	2017	2016	2017	2016
Other unrestricted revenue:				
Interest income and dividends	$ 638	$ 800	$ 2,111	$ 2,138
Nonoperating gains and losses, net:				
Interest income and dividends	16,862	15,030	51,174	43,077
Net realized gains on sales of investments	50,074	141,640	146,823	136,138
Net change in unrealized gains on investments	127,637	31,660	388,158	149,992
Equity method income on alternative investments	41,644	49,612	78,821	51,185
Investment management fees	(4,588)	(5,036)	(17,212)	(14,746)
	231,629	232,906	647,764	365,646
Other changes in net assets:				
Net change in unrealized gains (losses) on nontrading investments	(75)	52	(505)	(179)
Investment income on restricted investments	13,622	13,920	38,219	21,101
Total investment return	$ 245,814	$ 247,678	$ 687,589	$ 388,706

Pension Investments

In 2014, the System updated its investment strategy and modified the allocation of pension plan investments in the CCHS Retirement Plan (Plan), the System's primary defined benefit pension plan. The Plan ceased benefit accruals for substantially all employees as of December 31, 2009, and ceased benefit accruals for remaining employees at various intervals through December 31, 2012. 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 September 30, 2017, the Plan's investments were comprised of 8% cash and cash equivalents, 47% fixed-income investments, 29% equities, and 16% alternative investments.



Cleveland Skyline
Terminal Tower
Cleveland, Ohio

Long-term Debt

At September 30, 2017, outstanding bonds for the System totaled $3.353 billion, comprised of $2.613 billion (78%) of fixed-rate bonds, $11 million (<1%) of index-rate bonds and $729 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 September 30, 2017 was $620 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 $360 million of the variable-rate bonds are secured by irrevocable direct pay letters of credit or standby bond purchase agreements, and another $17 million is directly placed with a financial institution. Bonds supported by letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year, or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds are classified as current liabilities.

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

In November 2014, the System established the Cleveland Clinic Health System Obligated Group Commercial Paper Program, which provides for the issuance of the Series 2014A CP Notes. The Series 2014A CP Notes may be issued from time to time in a maximum outstanding face amount of $100 million and are supported by the System's self-liquidity program. At September 30, 2017, the System has $71.0 million of outstanding Series 2014A CP Notes.

Hillcrest Hospital

Mayfield Heights, Ohio

Outstanding hospital revenue bonds for the System as of September 30, 2017 and December 31, 2016 consist of the following:

Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	September 30 2017	December 31 2016
2017A	CCHS Obligated Group	Fixed	2043	$ 818,775	$ -
2017B	CCHS Obligated Group	Fixed	2043	169,255	-
2016	CCHS Obligated Group	Fixed	2046	325,000	325,000
2016	CCHS Obligated Group	Variable	2026	17,370	17,370
2014	CCHS Obligated Group	Fixed	2114	400,000	400,000
2014A	CCHS Obligated Group	CP Notes	2044	70,955	70,955
2013A	CCHS Obligated Group	Fixed / Index	2042	73,150	73,150
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	61,165	63,135
2012A	CCHS Obligated Group	Fixed	2039	451,135	460,080
2011A	CCHS Obligated Group	Fixed	2032	160,605	172,030
2011B	CCHS Obligated Group	Fixed	2031	27,785	29,120
2011C	CCHS Obligated Group	Fixed	2032	157,945	170,995
2009A	CCHS Obligated Group	Fixed	2039	-	305,400
2009B	CCHS Obligated Group	Fixed	2039	31,640	366,215
2008A	CCHS Obligated Group	Fixed	2043	7,930	409,740
2008B	CCHS Obligated Group	Variable	2043	327,575	369,250
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
2002	CCHS Obligated Group	Variable	2032	9,390	9,635
				$ 3,352,740	$ 3,485,140

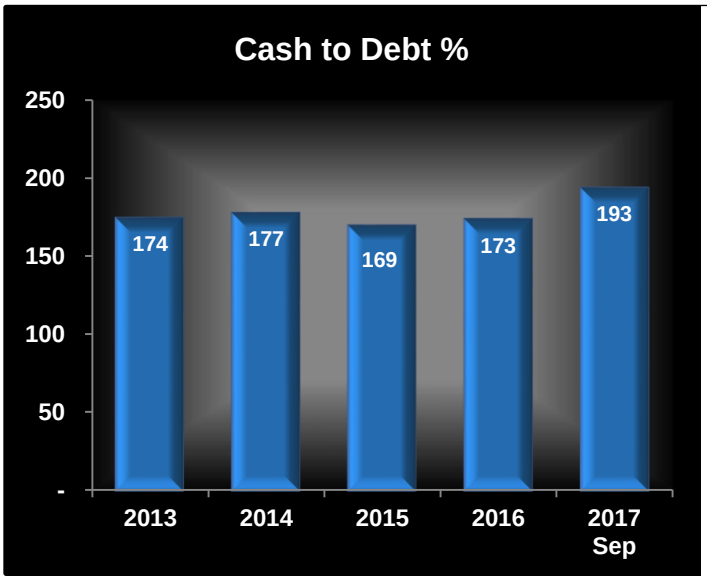
In August 2017, hospital revenue bonds totaling $988.0 million were issued for the benefit of the System. The proceeds of these bonds were used to refund all or a portion of the Series 2008A, 2008B, 2009A, 2009B and 2012A bonds and the pay the cost of issuance.

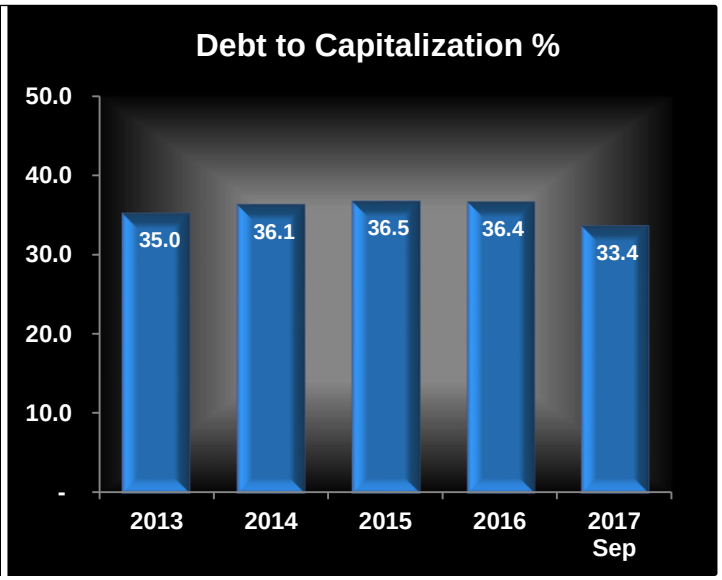
At September 30, 2017, the System has notes payable and capital leases totaling $531.3 million. Notes payable and capital leases include $376.6 million of notes payable, $60 million outstanding on a revolving credit facility and $94.7 million of capital lease liabilities primarily related to property and equipment.

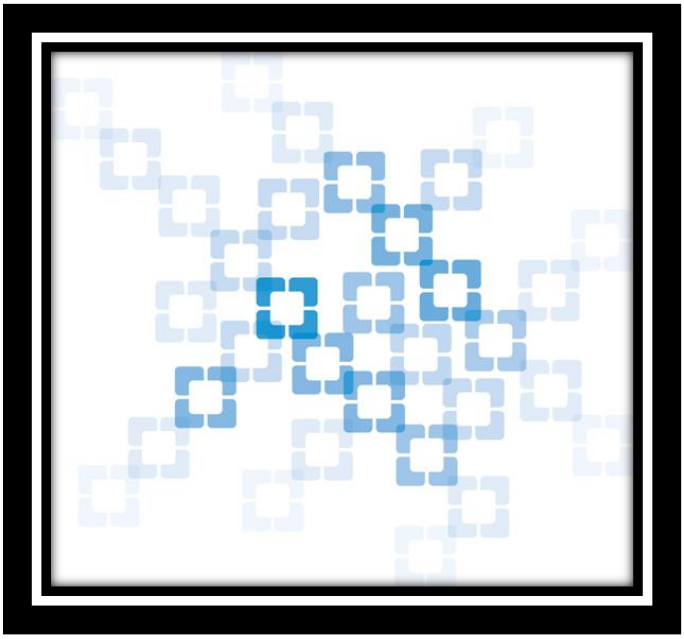
Included in notes payable is a term loan entered into by a Clinic subsidiary with a financial institution in 2015 for a principal amount of $375 million. The proceeds of the term loan were used to finance the System's international business strategy. The term loan matures in 2018 and bears interest at a variable-rate based on the London Interbank Offered Rate (LIBOR) index plus an applicable spread. The Clinic provides a guarantee on the term loan. The term loan is recorded in current portion of long-term debt as of September 30, 2017.

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 September 30, 2017 totaled $60.0 million and are recorded in notes payable in the consolidated balance sheets.

The following charts summarize cash-to-debt and debt-to-capitalization ratios for the System at December 31 for the last four years and September 30, 2017:







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

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

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

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended September 30, 2017 and 2016

Operating income for the System in the third quarter of 2017 was $39.7 million, resulting in an operating margin of 1.9%, as compared to operating income of $58.4 million and an operating margin of 2.9% in the third quarter of 2016. The lower operating income resulted from a 3.2% increase in operating expenses, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs and supplies, and lower outpatient volumes, which was partially attributable to extreme weather conditions in Florida. Inpatient volumes were higher in the third quarter of 2017 compared to the third quarter of 2016, which contributed to a 2.1% increase in total operating revenues. Nonoperating gains for the System were $187.9

million in the third quarter of 2017 compared to nonoperating gains of $229.3 million in the third quarter of 2016. The decrease from the prior year was primarily due a loss on extinguishment of debt that was recorded in connection with the issuance of the Series 2017 Bonds. Overall, the System reported an excess of revenues over expenses of $227.6 million in the third quarter of 2017 compared to an excess of revenues over expenses of $287.6 million in the third quarter of 2016.

The System's net patient service revenue increased $35.0 million (1.9%) in the third quarter of 2017 compared to the same period in 2016. The System experienced increases in inpatient acute admissions of 3.9% and inpatient surgical cases of 1.9%. Outpatient volumes were below the prior year, with decreases in outpatient surgical cases of 5.6%, outpatient observation cases of 5.3% and emergency department visits of 2.8%. 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 0.6% in the third quarter of 2017 compared to the same period in 2016. The System has experienced a corresponding decrease in managed care and commercial gross revenues as a percentage of total gross patient revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2017. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts decreased $6.9 million (8.8%) in the third quarter of 2017 compared to the same period in 2016. The decrease is primarily attributable to a decrease in self-pay revenue. The System has experienced a shift in revenues into governmental payors. The impact of the shift in payor mix on the provision for uncollectible accounts was partially offset by growth in deductible and copayment balances. The growth in high deductible and copayment health plans is an industry trend that will likely continue to accelerate. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances are generally more difficult to collect than traditional insurance payors. The System has implemented various initiatives to collect patient responsibility balances and continues to monitor the changing healthcare environment and the accelerating shift in reimbursement models that are expected to result in declining reimbursement from governmental and commercial payors. The System is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare more affordable to patients.

Other unrestricted revenues increased $0.9 million (0.4%) in the third quarter of 2017 compared to the same period in 2016. The increase in other unrestricted revenues was primarily due to an $8.9 million increase in outpatient pharmacy revenue and a $3.6 million increase in management service revenues. These increases were offset by a $7.5 million decrease in unrestricted gifts and assets released from restriction, a $3.2 million decrease in revenue related to research and education grants and a $2.7 million decrease in rent revenue primarily due to the vacated tenant leases in Grosvenor Place.

Total operating expenses increased $61.5 million (3.2%) in the third quarter of 2017 compared to the same period in 2016. Notable increases in expenses were experienced in salaries, wages

and benefits, pharmaceutical costs and supplies. To address the growth in expenses caused by inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System has implemented Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. The System continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries, wages and benefits increased $26.6 million (2.4%) in the third quarter of 2017 compared to the same period in 2016. Salaries, excluding benefits, increased $31.5 million (3.3%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the third quarter of 2017 and a 1.8% increase in average full-time equivalent employees in the third quarter of 2017 compared to the same period in 2016. Benefit costs decreased $4.8 million (3.2%) during the same period. The System experienced decreases in employee healthcare costs of $1.5 million and employee disability expenses of $2.2 million. These decreases were offset by a $2.2 million increase in FICA expenses primarily due to the increase in salaries and full-time equivalent employees.

Supplies expense increased $7.2 million (3.9%) in the third quarter of 2017 compared to the same period in 2016. The System experienced a $4.2 million increase in implantables and other medical supplies and a $3.0 million increase in non-medical supplies primarily due to increased dietary costs resulting from higher inpatient volumes.

Pharmaceutical costs increased $30.1 million (13.6%) in the third quarter of 2017 compared to the same period in 2016. The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $6.4 million in the third quarter of 2017 compared to the same period in 2016. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $1.6 million (1.2%) in the third quarter of 2017 compared to the same period in 2016. The System experienced a $3.7 million decrease in purchased medical services primarily related to expenses associated with the Cleveland Clinic Medicare ACO and a $5.3 million increase in various purchased non-medical service costs related to certain System projects and initiatives.

Administrative services decreased $4.6 million (9.6%) in the third quarter of 2017 compared to the same period in 2016. The decrease in administrative services was primarily due to a $3.4 decrease in expenses related to research projects and a $3.2 million decrease in consulting fees and professional services, which were offset by a $2.0 million increase in travel and education expenses.

Facilities expense increased $7.1 million (8.7%) in the third quarter of 2017 compared to the same period in 2016. The increase in facilities expense was primarily due to a $2.7 million increase in maintenance contracted expenses, a $1.5 million increase in operating costs associated with 33 Grosvenor Place and a $1.0 million increase in utility expenses.

Insurance expense decreased $9.2 million (57.9%) in the third quarter of 2017 compared to the same period in 2016. The decrease in insurance expense was primarily due to a decrease in professional malpractice expense due to favorable development of outstanding prior year claims. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense increased $1.2 million (3.4%) in the third quarter of 2017 compared to the same period in 2016. The System has experienced higher interest rates on its variable-rate bonds and notes payable in the third quarter of 2017 compared to 2016. In addition, the System issued $325.0 million of fixed-rate private placement debt in the third quarter of 2016 that bears interest at a fixed rate of 3.35%. This increase in debt was partially offset by $78.2 million of principal payments on bonds, notes and capital leases in the first nine months of 2017 and the issuance of the Series 2017 bonds in the third quarter of 2017 that refunded $1.1 billion of fixed-rate bonds at a lower interest rate.

Depreciation and amortization expenses increased $4.2 million (3.5%) in the third quarter of 2017 compared to the same period in 2016. Changes in depreciation include property, plant and equipment that was fully depreciated in 2016, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2017.

Special charges decreased $2.6 million (71.6%) in the third quarter of 2017 compared to the same period in 2016. The System incurred and recorded $1.0 million and $3.7 million of special charges in the third quarters of 2017 and 2016, respectively. Special charges in the third quarter of 2017 and 2016 include $1.0 million and $1.4 million, respectively, related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a detailed description of the terms of the agreement, refer to "LAKEWOOD HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets. Special charges in the third quarter of 2016 also include $2.3 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place. The System is converting the building from office space to a healthcare facility.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $187.9 million in the third quarter of 2017 compared to a net gain of $229.3 million in the third quarter of 2016, resulting in an unfavorable variance of $41.3 million. Investment returns were unfavorable by $1.3 million in the third quarter of 2017 compared to the same period in 2016. The System's long-term investment portfolio reported investment gains of 2.9% for the third quarter of 2017, which is higher than the portfolio's benchmark gain of 2.7% but lower than investment gains of 3.1% experienced in the third quarter of 2016.

Derivative losses were favorable by $0.5 million in the third quarter of 2017 compared to the same period in 2016. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements. The System also experienced a $2.5 million favorable variance in other nooperating gains related to foreign currency transaction gains and $2.9 million favorable variance in other nonoperating gains related to net periodic pension cost. The System adopted Accounting Standard Update 2017-07 on January 1, 2017 and retrospectively adjusted the statement of operations for the third quarter of 2016. The impact of adoption on the statement of operations for the third quarter of 2016 was a reclassification of $0.1 million that increased other nonoperating gains and losses, with a corresponding increase to salaries, wages and benefits and decrease to operating income. Other nonoperating gains and losses also includes a loss on the extinguishment of debt of $46.2 million in the first nine months of 2017 related to bonds that were refunded in connection with the issuance of the Series 2017 Bonds.

For the Nine Months Ended September 30, 2017 and 2016

Operating income for the System in the first nine months of 2017 was $230.9 million, resulting in an operating margin of 3.7%, as compared to operating income of $105.9 million and an operating margin of 1.8% in the first nine months of 2016. The higher operating income resulted from a 5.9% increase in total unrestricted revenues, which was primarily due to strong patient volumes and a non-patient payment received from a payor in the second quarter of 2017. Operating expenses increased 3.8% in the first nine months of 2017 compared to the same period of 2016, with notable increases experienced in salaries, wages and benefits, pharmaceutical costs and supplies. Nonoperating gains for the System were $608.6 million in the first nine months of 2017 compared to nonoperating gains of $291.5 million in the first nine months of 2016. The increase from the prior year was primarily due to gains on investments attributable to overall changes in the financial markets and a favorable variance in derivative gains and losses. Overall, the System reported an excess of revenues over expenses of $839.5 million in the first nine months of 2017 compared to an excess of revenues over expenses of $397.4 million in the first nine months of 2016.

The System's net patient service revenue increased $242.2 million (4.3%) in the first nine months of 2017 compared to the same period in 2016. The System experienced increases in inpatient acute admissions of 4.5%, total surgical cases of 0.4% and outpatient evaluation and management visits of 4.4% in the first nine months of 2017 compared to the same period in 2016. Total acute case mix for the System was higher in the first nine months of 2017 compared to the same period in 2016, which has resulted in more inpatient revenue per patient. 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 0.9% in the first nine months of 2017 compared to the same period in 2016. The System has experienced a corresponding decrease in managed care and commercial gross revenues as a percentage of total gross patient revenues. This shift in the gross revenue payor mix has negatively impacted the revenue realization of the System. However, net patient revenue has benefited from rate increases on the System's managed care

contracts that became effective in 2017. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts increased $2.4 million (1.0%) in the first nine months of 2017 compared to the same period in 2016. The increase is primarily attributable to increases in net patient service revenue and growth in deductible and copayment balances. The growth in high deductible and copayment health plans is an industry trend that will likely continue to accelerate. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances are generally more difficult to collect than traditional insurance payors. The System has implemented various initiatives to collect patient responsibility balances and continues to monitor the changing healthcare environment and the accelerating shift in reimbursement models that are expected to result in declining reimbursement from governmental and commercial payors. The System is focused on strategic initiatives that are designed to promote growth and increase value to make healthcare more affordable to patients.

Other unrestricted revenues increased $107.5 million (18.6%) in the first nine months of 2017 compared to the same period in 2016. The increase in other unrestricted revenues was primarily due to a $70.0 million non-patient payment received from a payor in the second quarter of 2017, a $19.6 million increase in outpatient pharmacy revenue, a $17.9 million increase in management service contract revenue, a $9.1 million increase in revenue related to a Center for Medicare and Medicaid Services program, a $4.0 million increase in revenue related to research and education grants, a $2.4 million increase in equity earnings on joint venture investments and a $2.8 million increase related to the sale of a CCF Innovations spin-off company. These increases were offset by a $12.0 million decrease in rent revenue primarily due to the vacated tenant leases in Grosvenor Place and a $7.2 million decrease in unrestricted gifts and assets released from restriction.

Total operating expenses increased $222.5 million (3.8%) in the first nine months of 2017 compared to the same period in 2016. Notable increases in expenses were experienced in salaries, wages and benefits, pharmaceutical costs and supplies, which are partially due to higher patient volumes. To address the growth in expenses caused by inflationary pressures in many expense categories such as salaries, benefits and specialized pharmaceuticals, the System has implemented Care Affordability initiatives. Care Affordability initiatives are designed to transform patient care and business models in an effort to provide quality, affordable patient care. The System identifies, quantifies and implements these initiatives through an extensive analysis of the cost structure. The System continues to develop and implement cost management and containment plans designed to make a more affordable care model for patients and to enable investments in key strategic initiatives.

Salaries, wages and benefits increased $113.8 million (3.4%) in the first nine months of 2017 compared to the same period in 2016. Salaries and wages, excluding benefits, increased $109.8 million (3.9%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2017 and a 2.4% increase in average full-time equivalent employees in the first nine months of 2017 compared to the same period in 2016. Benefit costs increased $4.0 million (0.8%) during the same period. FICA expenses increased $8.8 million primarily due to the increase in salaries

and full-time equivalent employees. This increase was offset by a $2.6 million decrease in employee health care costs.

Supplies expense increased $30.3 million (5.4%) in the first nine months of 2017 compared to the same period in 2016. The System experienced a $27.5 million increase in implantables and other medical supplies primarily due to higher surgical volumes and a $2.8 million increase in non-medical supplies.

Pharmaceutical costs increased $72.6 million (11.4%) in the first nine months of 2017 compared to the same period in 2016. The increase is primarily due to higher costs and increased utilization in the oncology departments. In addition, the System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $14.9 million in the first nine months of 2017 compared to the same period in 2016. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $16.9 million (4.5%) in the first nine months of 2017 compared to the same period in 2016. The increase in purchased service expenses was primarily due to a $0.4 million increase in purchased medical services primarily related to external lab services and a $16.5 million increase in various purchased non-medical service costs related to certain System projects and initiatives.

Administrative services decreased $3.9 million (2.8%) in the first nine months of 2017 compared to the same period in 2016. The decrease in administrative services was primarily due to a $4.0 million decrease in consulting fees and professional services and a $2.5 million decrease in expenses related to research projects, which were offset by a $2.6 million increase in travel and education expenses.

Facilities expense decreased $4.2 million (1.6%) in the first nine months of 2017 compared to the same period in 2016. The decrease in facilities expense was primarily due to a $4.4 million decrease in rent expenses due to the expiration of various operating leases and a $2.8 million decrease in utility expenses. These decreases were offset by a $1.9 million increase in operating costs associated with 33 Grosvenor Place.

Insurance expense decreased $8.4 million (15.1%) in the first nine months of 2017 compared to the same period in 2016. The decrease in insurance expense was primarily due to a decrease in professional malpractice expense due to favorable development of outstanding prior year claims. The System utilizes an independent actuarial firm to review professional malpractice loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last several years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense increased $8.0 million (8.0%) in the first nine months of 2017 compared to the same period in 2016. The System has experienced higher interest rates on its variable-rate bonds and notes payable in the first nine months of 2017 compared to the same period in

2016. In addition, the System issued $325.0 million of fixed-rate private placement debt in the third quarter of 2016 that bears interest at a fixed rate of 3.35%. This increase in debt was partially offset by $78.2 million of principal payments on bonds, notes and capital leases in the first nine months of 2017 and the issuance of the Series 2017 bonds in the third quarter of 2017 that refunded $1.1 billion of fixed-rate bonds at a lower interest rate.

Depreciation and amortization expenses increased $15.9 million (4.5%) in the first nine months of 2017 compared to the same period in 2016. Changes in depreciation include property, plant and equipment that was fully depreciated in 2016, offset by depreciation for property, plant and equipment that was acquired and placed into service in 2017.

Special charges decreased $18.5 million (80.7%) in the first nine months of 2017 compared to the same period in 2016. The System incurred and recorded $4.4 million and $22.9 million of special charges in the first nine months of 2017 and 2016, respectively. Special charges in the first nine months of 2017 and 2016 include $4.4 million and $15.2 million, respectively, related to Lakewood Hospital and the agreement between the City of Lakewood, LHA and the Clinic that outlines the transition of healthcare services in the City of Lakewood. For a detailed description of the terms of the agreement, refer to "LAKEWOOD HOSPITAL ASSOCIATION." Special charges incurred and recorded for LHA primarily relate to accelerated depreciation expense and other property, plant and equipment costs on LHA assets. Special charges in the first nine months of 2016 also includes $7.7 million of statutory compensation payments related to the termination of tenant leases at Grosvenor Place. The System is converting the building from office space to a healthcare facility.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $608.6 million in the first nine months of 2017 compared to a net gain of $291.5 million in the first nine months of 2016, resulting in a favorable variance of $317.1 million. Investment returns were favorable by $282.1 million in the first nine months of 2017 compared to the same period in 2016. The System's long-term investment portfolio reported investment gains of 9.3% for the first nine months of 2017, which is higher than the portfolio's benchmark gain of 8.7% and higher than investment gains of 5.4% experienced in the first nine months of 2016. Derivative losses were favorable by $61.2 million in the first nine months of 2017 compared to the same period in 2016. Derivative gains and losses result from changes in foreign currency exchange rates associated with the System's foreign currency derivative contracts and changes in the interest rate benchmark associated with the System's interest rate swap contracts, including net interest paid or received under the swap agreements. The System also experienced an $8.6 million favorable variance in other nonoperating gains related to net periodic pension cost. The System adopted Accounting Standard Update 2017-07 on January 1, 2017 and retrospectively adjusted the statement of operations for the first nine months of 2016. The impact of adoption on the statement of operations for the first nine months of 2016 was a reclassification of $0.2 million that increased other nonoperating gains and losses, with a corresponding increase to salaries, wages and benefits and decrease to operating income. Other nonoperating gains and losses also includes losses on the extinguishment of debt of $46.2 million and $3.9 million in the first nine months of 2017 and 2016, respectively, related to bonds that were refunded or redeemed in each period.

BALANCE SHEET – SEPTEMBER 30, 2017 COMPARED TO DECEMBER 31, 2016

Patient accounts receivable, net of allowances for uncollectible accounts, decreased $107.9 million (10.2%) from December 31, 2016 to September 30, 2017. The decrease in patient receivables is partially due to cash collection efforts and other initiatives to reduce patient receivable balances and create efficiencies in the revenue cycle process, including the implementation of EAPM. EAPM was implemented at the Clinic in 2016. Medina Hospital and Marymount Hospital implemented EAPM in the second quarter of 2017, and Akron General Medical Center and Lodi Hospital implemented EAPM in the third quarter of 2017. Partially offsetting this decrease is 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. Days revenue outstanding for the System decreased from 51 days at December 31, 2016 to 47 days at September 30, 2017. The System records estimated allowances that result in patient accounts receivable being reported at the net amount expected to be received.

Investments for current use 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 nine months of 2017.

Other current assets increased $33.4 million (8.4%) from December 31, 2016 to September 30, 2017. The increase in other current assets was primarily due to a $15.3 million increase in prepaid expenses driven by annual maintenance contract and international prepaid payments and a $15.0 million increase in receivables related to the timing of receipts for various Medicare and Medicaid programs.

Unrestricted long-term investments increased $1.0 billion (15.6%) from December 31, 2016 to September 30, 2017. The increase was primarily due to positive unrestricted investment returns and cash flow from operations and includes the transfer of cash and cash equivalents form short-term operating cash to unrestricted long-term investments. Total unrestricted cash, cash equivalents and long-term investments increased $777.0 million from December 31, 2016 to September 30, 2017. The System experienced $1,238.9 million of net positive cash flow from operations and investment income in the first nine months of 2017, which was partially offset by net capital expenditures of $413.6 million and principal payments on long-term debt of $78.2 million.

Funds held by trustees increased $8.2 million (10.8%) from December 31, 2016 to September 30, 2017. The increase in funds held by trustees is primarily due to an $8.4 million increase of collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance increased $15.5 million (12.1%) from December 31, 2016 to September 30, 2017. The increase in self-insurance assets is primarily due to investment gains experienced in the System's captive insurance subsidiary and premiums received by the captive insurance subsidiary in excess of reimbursement payments for claims previously settled and paid by other System entities.

Donor restricted assets increased $67.8 million (11.1%) from December 31, 2016 to September 30, 2017. The increase in donor restricted assets was primarily from investment gains on restricted investments and the receipt of donor restricted gifts in excess of expenditures from restricted funds.

Net property, plant and equipment increased $48.4 million (1.1%) from December 31, 2016 to September 30, 2017. The System had net expenditures for property, plant and equipment of $413.6 million, offset by depreciation expense of $370.1 million, which includes $2.6 million of accelerated depreciation expense recorded in special charges. Increases in PPE also resulted from $25.9 million of foreign currency translation gains. Capital expenditures in 2017 include amounts paid on retainage liabilities recorded at December 31, 2016 and exclude assets acquired through capital lease arrangements. Retainage liabilities decreased $32.6 million and new capital leases totaled $11.6 million in the first nine months of 2017. Expenditures for property, plant and equipment were incurred at numerous facilities across the System and include expenditures for strategic construction, expansion and technological investment as well as replacement of existing facilities and equipment. For a complete description of many of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets decreased $21.0 million (3.3%) from December 31, 2016 to September 30, 2017. The decrease in noncurrent assets was primarily due to a $48.8 million decrease in donated property assets that were liquidated in the second quarter of 2017. The Clinic received the donated property in prior years to fulfill a pledge receivable. This decrease was offset by $14.0 million of long-term escrow deposits in 2017 related to international transactions, a $5.8 million increase in the value of perpetual and charitable trusts and interests in foundations and a $5.0 million increase in long-term pledge receivables.

Accounts payable decreased $98.1 million (20.3%) from December 31, 2016 to September 30, 2017. The decrease in accounts payable was primarily attributable to the timing of payment processing for trade payables, a $32.6 million decrease in retainage liabilities and a $12.5 million decrease in outstanding checks.

Compensation and amounts withheld from payroll increased $55.8 million (17.3%) from December 31, 2016 to September 30, 2017. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $375.6 million (>100%) from December 31, 2016 to September 30, 2017. The System reclassified a $375 million term loan that matures in the second quarter of 2018 from long-term to current. The term loan was executed in 2015 to fund the System's international business strategy. The System expects to refinance the term loan prior to its maturity date. The System also reclassified other regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments of $78.2 million made in the first nine months of 2017.

Variable rate debt classified as current decreased $32.7 million (6.2%) from December 31, 2016 to September 30, 2017. Long-term debt classified as current consists of variable-rate bonds supported by the System's self-liquidity program and bonds with letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds. The decrease in

variable rate debt classified as current is primarily due to the refunding of $30.4 million of Series 2008B bonds in connection with the issuance of the Series 2017 bonds, which qualify to be reported in long-term debt.

Other current liabilities decreased $33.4 million (7.2%) from December 31, 2016 to September 30, 2017. The decrease in other current liabilities is primarily due to a $40.8 million decrease in accrued interest payable related to bonds that pay interest semi-annually in January and July of each year and an $11.1 million decrease in the fair value of the System's foreign exchange derivative contracts. These decreases were offset by an $18.6 million increase in state franchise fee liabilities due to the timing of payments for this program and a $14.4 million reclassification of pledges payable from long-term to current.

Hospital revenue bonds increased $16.6 million (0.6%) from December 31, 2016 to September 30, 2017. The increase in hospital revenue bonds is primarily due to the issuance of the Series 2017 bonds, which refunded $1.1 billion of various bond series. The refunded bonds included $30.4 million of bonds that were previously recorded as variable rate debt classified as current. Partially offsetting the increase in hospital revenue bonds is 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 $381.4 million (73.8%) from December 31, 2016 to September 30, 2017. The decrease is primarily due to the reclassification of a $375 million term loan that matures in the second quarter of 2018 from long-term to current. The System also reclassified other regularly scheduled principal payments from long-term to current, offset by $11.6 million in new capital leases recorded in the first nine months of 2017.

Professional and general insurance liability reserves increased $6.5 million (4.5%) from December 31, 2016 to September 30, 2017. The increase is due to expenses recorded for the accrual of current year claim estimates in excess of claim liability payments.

Accrued retirement benefits decreased $23.1 million (4.8%) from December 31, 2016 to September 30, 2017. The change in accrued retirement benefits is comprised of a $19.8 million decrease in the System's defined benefit pension plan liabilities and a $3.3 million decrease in other postretirement benefit liabilities. The decrease in defined benefit pension plan liabilities is primarily due to net periodic pension 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 (4.9%) from December 31, 2016 to September 30, 2017. The decrease in other noncurrent liabilities is primarily due to a $14.1 million reclassification of pledges payable from long-term to current, a $6.4 million decrease in derivative liabilities associated with changes in the fair value of the System's interest rate swap derivative contracts and a $5.9 million decrease in third-party liabilities. These increases were offset by a $2.3 million increase in long-term deferred gift annuity liabilities.

Total net assets increased $959.7 million (12.0%) from December 31, 2016 to September 30, 2017. Unrestricted net assets increased $936.6 million (13.2%) primarily due to an excess of revenues over expenses of $839.5 million, assets released from restriction for capital purposes of $72.0 million and foreign currency translation gains of $27.1 million. Temporarily restricted net assets increased $7.3 million (1.2%), primarily due to $64.2 million in temporarily restricted gifts and $38.2 million in

net investment income offset by $98.5 million in assets released from restrictions for operations and capital purposes. Permanently restricted net assets increased $15.8 million (5.1%) primarily due to $14.3 million of permanently restricted gifts and a $1.5 million increase in the value of perpetual trusts.

Cleveland Clinic 1921
Cleveland, Ohio

FORWARD-LOOKING STATEMENTS

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

- Changes to the Medicare and Medicaid reimbursement systems resulting in reductions in payments and/or changes in eligibility of patients to qualify for Medicare and Medicaid;
- Legislative reforms or actions that reduce the payment for, and/or utilization of, healthcare services, such as the Patient Protection and Affordable Care Act and/or draft legislation to address reimbursement cuts related to the Sustainable Growth Rate Formulas;
- Possible repeal and/or replacement of the Patient Protection and Affordable Care Act;
- 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 proposed Tax Cuts and Jobs Act tax reform legislation;
- 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.