Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended March 31, 2020

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

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Unaudited Consolidated Balance Sheets

($ in thousands)

	March 31 2020	December 31 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 590,172	$ 505,729
Patient receivables	1,274,617	1,299,256
Investments for current use	59,355	178,800
Other current assets	527,693	488,668
Total current assets	2,451,837	2,472,453
Investments:		
Long-term investments	8,366,472	9,272,287
Funds held by trustees	265,154	225,207
Assets held for self-insurance	119,447	157,972
Donor restricted assets	819,370	860,120
	9,570,443	10,515,586
Property, plant, and equipment, net	5,834,479	5,865,590
Other assets:		
Pledges receivable, net	153,367	154,918
Trusts and interests in foundations	108,997	113,437
Operating lease right-of-use assets	314,917	325,960
Other noncurrent assets	518,964	526,440
	1,096,245	1,120,755
Total assets	$ 18,953,004	$ 19,974,384

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	March 31 2020	December 31 2019
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 458,325	$ 536,680
Compensation and amounts withheld from payroll	488,263	430,921
Current portion of long-term debt	99,224	95,405
Variable rate debt classified as current	529,841	529,841
Other current liabilities	527,067	573,923
Total current liabilities	2,102,720	2,166,770
Long-term debt	4,579,601	4,698,648
Other liabilities:		
Professional and general insurance liability reserves	176,217	164,008
Accrued retirement benefits	316,731	347,064
Operating lease liabilities	286,869	296,668
Other noncurrent liabilities	598,755	542,091
	1,378,572	1,349,831
Total liabilities	8,060,893	8,215,249
Net assets:		
Without donor restrictions	9,717,615	10,540,856
With donor restrictions	1,174,496	1,218,279
Total net assets	10,892,111	11,759,135
Total liabilities and net assets	$ 18,953,004	$ 19,974,384

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months Ended March 31	
	2020	2019
Unrestricted revenues		
Net patient service revenue	$ 2,332,056	$ 2,282,885
Other	252,646	239,454
Total unrestricted revenues	2,584,702	2,522,339
Expenses		
Salaries, wages, and benefits	1,487,953	1,411,157
Supplies	269,764	249,275
Pharmaceuticals	330,131	301,899
Purchased services and other fees	177,258	164,195
Administrative services	49,758	49,588
Facilities	90,938	95,769
Insurance	22,681	25,234
	2,428,483	2,297,117
Operating income before interest, depreciation, amortization, and special charges	156,219	225,222
Interest	41,023	39,751
Depreciation and amortization	155,118	149,268
Operating (loss) income	(39,922)	36,203
Nonoperating gains and losses		
Investment return	(722,520)	371,640
Derivative loss	(77,519)	(8,487)
Other, net	9,354	429,253
Net nonoperating gains and losses	(790,685)	792,406
(Deficiency) excess of revenues over expenses	(830,607)	828,609

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

($ in thousands)

Changes in Net Assets

	Three Months Ended March 31	
	2020	2019
Changes in net assets without donor restrictions:		
(Deficiency) excess of revenues over expenses	$ (830,607)	$ 828,609
Donated capital	18	-
Net assets released from restriction for capital purposes	3,073	3,647
Retirement benefits adjustment	(715)	1,323
Foreign currency translation	3,579	457
Other	1,411	29
(Decrease) increase in net assets without donor restrictions	(823,241)	834,065
Changes in net assets with donor restrictions:		
Gifts and bequests	29,229	35,470
Net investment (loss) income	(56,706)	26,008
Net assets released from restrictions used for operations included in other unrestricted revenues	(12,529)	(9,088)
Net assets released from restriction for capital purposes	(3,073)	(3,647)
Change in interests in foundations	(2,158)	1,008
Change in value of perpetual trusts	63	(582)
Member substitution contribution	-	71,748
Other	1,391	8
(Decrease) increase in net assets with donor restrictions	(43,783)	120,925
(Decrease) increase in net assets	(867,024)	954,990
Net assets at beginning of year	11,759,135	9,519,887
Net assets at end of period	$ 10,892,111	$ 10,474,877

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31	
	2020	2019
Operating activities and net nonoperating gains and losses		
(Decrease) increase in net assets	$ (867,024)	$ 954,990
Adjustments to reconcile (decrease) increase in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:		
Retirement benefits adjustment	715	(1,323)
Net realized and unrealized losses (gains) on investments	793,855	(384,703)
Depreciation and amortization	155,090	149,268
Foreign currency translation gain	(3,579)	(457)
Donated capital	(18)	-
Restricted gifts, bequests, investment income, and other	29,572	(61,904)
Accreted interest and amortization of bond premiums	(1,497)	(1,458)
Net loss in value of derivatives	71,360	5,060
Member substitution contribution	-	(500,155)
Changes in operating assets and liabilities:		
Patient receivables	24,639	(92,967)
Other current assets	(48,624)	(44,986)
Other noncurrent assets	7,261	(324,161)
Accounts payable and other current liabilities	(55,525)	(58,878)
Other liabilities	(16,855)	338,457
Net cash provided by (used in) operating activities and net nonoperating gains and losses	89,370	(23,217)
Financing activities		
Proceeds from long-term borrowings	-	2,624
Principal payments on long-term debt	(70,661)	(101,905)
Change in pledges receivables, trusts and interests in foundations	13,488	3,274
Restricted gifts, bequests, investment income, and other	(29,572)	61,904
Net cash (used in) financing activities	(86,745)	(34,103)
Investing activities		
Expenditures for property, plant and equipment	(174,734)	(146,610)
Proceeds from sale of property, plant and equipment	1,887	-
Net change in cash equivalents reported in long-term investments	127,502	18,441
Purchases of investments	(1,860,722)	(1,903,378)
Sales of investments	1,887,543	1,946,347
Member substitution cash contribution	-	16,402
Net cash (used in) investing activities	(18,524)	(68,798)
Effect of exchange rate changes on cash	(16,068)	3,764
(Decrease) in cash, cash equivalents and restricted cash	(31,967)	(122,354)
Cash, cash equivalents and restricted cash at beginning of year	637,286	445,121
Cash, cash equivalents and restricted cash at end of period	$ 605,319	$ 322,767

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

The accompanying unaudited consolidated financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) for interim financial information. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation have been included and are of a normal and recurring nature. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2019.

2. Organization and Consolidation

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

The System is the leading provider of healthcare services in Northeast Ohio. As of March 31, 2020, the System operates 18 hospitals with approximately 4,900 staffed beds. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by the Clinic. The System operates 21 outpatient Family Health Centers, 11 ambulatory surgery centers, as well as numerous physician offices, which are located throughout Northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In Florida, the System operates five hospitals and a clinic located throughout Southeast Florida, outpatient family health centers in Port St. Lucie, Stuart and West Palm Beach, an outpatient family health and ambulatory surgery center in Coral Springs, and numerous physician offices located throughout Southeast Florida. In addition, the System operates a health and wellness center and a sports medicine clinic in Toronto, Canada and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, and Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that is part of Mubadala Development Company's network of healthcare facilities located in Abu Dhabi, United Arab Emirates with 364 staffed beds.

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

3. Accounting Policies

Recent Accounting Pronouncements

Adopted

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement, Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement*. This ASU intends to improve the effectiveness of disclosures in the notes to financial statements by modifying disclosure requirements for fair value measurements. The System adopted ASU 2018-13 on January 1, 2020. The adoption of ASU 2018-13 had no impact on the consolidated financial statements.

3. Accounting Policies (continued)

Not Yet Adopted

In August 2018, the FASB issued ASU 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General, Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans*. This ASU intends to improve the effectiveness of disclosures in the notes to financial statements by modifying disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. The ASU is effective for the System for annual reporting periods ending after December 15, 2021, with early adoption permitted. The System is currently assessing the impact that ASU 2018-14 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

In August 2018, the FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software, Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract*. This ASU aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The ASU is effective for the System for annual reporting periods beginning after December 15, 2020, and interim periods beginning after December 15, 2021, with early adoption permitted. The System is currently assessing the impact that ASU 2018-15 will have on its consolidated financial statements and will adopt the provisions upon the effective date.

4. Use of Estimates

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

5. Net Patient Service Revenue

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

5. Net Patient Service Revenue (continued)

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

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

The System is utilizing the portfolio approach practical expedient in ASC 606 for contracts related to net patient service revenue. The System accounts for the contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio. The portfolios consist of major payor classes for inpatient revenue and outpatient revenue. Based on historical collection trends and other analyses, the System has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

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

5. Net Patient Service Revenue (continued)

Generally, patients who are covered by third-party payors are responsible for patient responsibility balances, including deductibles and coinsurance, which vary in amount. The System estimates the transaction price for patients with deductibles and coinsurance based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any explicit price concessions, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Adjustments arising from a change in the transaction price were not significant in the first three months of 2020 or 2019.

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

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

Settlements with third-party payors for retroactive adjustments due to reviews and audits are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care in the period the related services are provided. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the System's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known or as years are settled or are no longer subject to such reviews and audits. Adjustments arising from a change in estimated settlements were not significant in the first three months of 2020 or 2019.

5. Net Patient Service Revenue (continued)

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

Net patient service revenue by major payor source, net of price concessions, for the three months ended March 31, 2020 and 2019, is as follows (in thousands):

	2020		**2019**	
Medicare	**$ 912,943**	**39%**	$ 884,488	38%
Medicaid	**236,743**	**10**	179,108	8
Managed care and commercial	**1,171,595**	**50**	1,208,228	53
Self-pay	**10,775**	**1**	11,061	1
Net patient service revenue	**$ 2,332,056**	**100%**	$ 2,282,885	100%

6. Cash and Cash Equivalents

The System considers all highly liquid investments with original maturities of three months or less when purchased to be cash equivalents. Cash equivalents are recorded at fair value in the consolidated balance sheets and exclude amounts held for long-term investment purposes and amounts included in long-term investment portfolios as those amounts are commingled with long-term investments.

The reconciliation of cash, cash equivalents and restricted cash within the consolidated balance sheets that comprise the amount reported on the consolidated statements of cash flows at March 31, 2020 and December 31, 2019 is as follows (in thousands):

	2020	**2019**
Cash and cash equivalents	**$ 590,172**	$ 505,729
Investments for current use	**–**	119,446
Restricted cash in investments	**15,147**	12,111
Total cash, cash equivalents and restricted cash	**$ 605,319**	$ 637,286

Investments for current use includes restricted cash deposits with the trustee to fund current principal and interest payments on debt. Restricted cash in investments includes amounts held by the System's captive insurance subsidiary and restricted cash for various programs.

7. Fair Value Measurements

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

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

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

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

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

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

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

7. Fair Value Measurements (continued)

The following tables present the financial instruments measured at fair value on a recurring basis as of March 31, 2020 and December 31, 2019, based on the valuation hierarchy (in thousands):

March 31, 2020	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 605,319	$ –	$ –	$ 605,319
Money market funds	1,028,583	5,358	–	1,033,941
Fixed income securities:				
U.S. treasuries	1,081,221	–	–	1,081,221
U.S. government agencies	–	54,198	–	54,198
U.S. corporate	–	367,054	–	367,054
U.S. government agencies asset-backed securities	–	415,016	–	415,016
Corporate asset-backed securities	–	178,768	–	178,768
Foreign	–	178,564	–	178,564
Fixed income mutual funds	117,320	–	–	117,320
Common and preferred stocks:				
U.S.	221,203	–	–	221,203
Foreign	216,159	8,928	–	225,087
Equity mutual funds	81,214	–	–	81,214
Total cash and investments	3,351,019	1,207,886		4,558,905
Perpetual and charitable trusts	–	86,019	–	86,019
Total assets at fair value	$ 3,351,019	$ 1,293,905	$ –	$ 4,644,924
Liabilities				
Interest rate swaps	$ –	$ 182,079	$ –	$ 182,079
Foreign currency forward contracts	–	24,874	–	24,874
Total liabilities at fair value	$ –	$ 206,953	$ –	$ 206,953

7. Fair Value Measurements (continued)

December 31, 2019	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	$ 637,286	$ –	$ –	$ 637,286
Money market funds	1,158,348	167	–	1,158,515
Fixed income securities:				
U.S. treasuries	1,146,082	–	–	1,146,082
U.S. government agencies	–	31,698	–	31,698
U.S. corporate	–	334,914	–	334,914
U.S. government agencies asset-backed securities	–	325,341	–	325,341
Corporate asset-backed securities	–	167,647	–	167,647
Foreign	–	151,625	–	151,625
Fixed income mutual funds	120,239	–	–	120,239
Common and preferred stocks:				
U.S.	311,327	–	–	311,327
Foreign	311,283	8,840	–	320,123
Equity mutual funds	142,424	–	–	142,424
Total cash and investments	3,826,989	1,020,232		4,847,221
Perpetual and charitable trusts	–	88,301	–	88,301
Total assets at fair value	$ 3,826,989	$ 1,108,533	$ –	$ 4,935,522
Liabilities				
Interest rate swaps	$ –	$ 131,004	$ –	$ 131,004
Foreign currency forward contracts	–	2,879	–	2,879
Total liabilities at fair value	$ –	$ 133,883	$ –	$ 133,883

7. Fair Value Measurements (continued)

Financial instruments at March 31, 2020 and December 31, 2019 are reflected in the consolidated balance sheets as follows (in thousands):

	March 31, 2020	December 31, 2019
Cash, cash equivalents, and investments measured at fair value	**$ 4,558,905**	$ 4,847,221
Commingled funds measured at net asset value	**2,026,306**	2,722,100
Alternative investments accounted for under the equity method	**3,634,759**	3,630,794
Total cash, cash equivalents, and investments	**$ 10,219,970**	$ 11,200,115
Perpetual and charitable trusts measured at fair value	**$ 86,019**	$ 88,301
Interests in foundations	**22,978**	25,136
Trusts and interests in foundations	**$ 108,997**	$ 113,437

Interest rate swaps and forward currency forward contracts (*Note 8*) are reported in other current liabilities and other noncurrent liabilities in the consolidated balance sheets.

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

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

The fair value of perpetual and charitable trusts in which the System receives periodic payments from the trust is determined based on the present value of expected cash flows to be received from the trust using discount rates ranging from 1.0% to 6.5%, which are based on Treasury yield curve interest rates or the assumed yield of the trust assets. The fair value of charitable trusts in which the System is a remainder beneficiary is based on the System's beneficial interest in the investments held in the trust, which are measured at fair value.

7. Fair Value Measurements (continued)

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

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

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

8. Derivative Instruments

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

The System's objective with respect to interest rate risk is to manage the risk of rising interest rates on the System's variable rate debt. Consistent with its interest rate risk management objective, the System entered into various interest rate swap agreements with a total outstanding notional amount of $602.8 million and $615.8 million at March 31, 2020 and December 31, 2019, 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.

8. Derivative Instruments (continued)

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

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at March 31, 2020	Notional Amount at December 31, 2019
Fixed	2021	3.21%	68% of LIBOR	**$ 26,865**	$ 28,525
Fixed	2024	3.42%	68% of LIBOR	**24,250**	25,700
Fixed	2024	3.45%	67% of LIBOR	**6,185**	6,185
Fixed	2027	3.56%	68% of LIBOR	**111,226**	115,757
Fixed	2028	5.12%	100% of LIBOR	**34,195**	35,430
Fixed	2028	3.51%	68% of LIBOR	**26,405**	27,395
Fixed	2030	5.07%	100% of LIBOR	**56,350**	56,350
Fixed	2030	5.06%	100% of LIBOR	**56,325**	56,325
Fixed	2031	3.04%	68% of LIBOR	**40,925**	44,000
Fixed	2032	4.32%	79% of LIBOR	**2,066**	2,091
Fixed	2032	4.33%	70% of LIBOR	**4,133**	4,183
Fixed	2032	3.78%	70% of LIBOR	**2,066**	2,091
Fixed	2032	3.58%	67% of LIBOR	**10,015**	10,015
Fixed	2036	4.90%	100% of LIBOR	**48,500**	48,500
Fixed	2036	4.90%	100% of LIBOR	**75,250**	75,250
Fixed	2037	4.62%	100% of SIFMA	**56,980**	56,980
Fixed	2039	4.62%	68% of LIBOR	**21,025**	21,025
				$ 602,761	$ 615,802

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

In November 2018, the System entered into three foreign currency forward contracts, expiring between May 2020 and April 2021, with a total outstanding notional amount of $336.2 million at both March 31, 2020 and December 31, 2019.

8. Derivative Instruments (continued)

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

	Derivative Liabilities			
	March 31, 2020		December 31, 2019	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives not designated as hedging instruments				
Interest rate swap agreements	Other noncurrent liabilities	**$ 182,079**	Other noncurrent liabilities	$ 131,004
Foreign currency contracts	Other current liabilities	**$ 19,124**	Other current liabilities	$ 1,871
Foreign currency contracts	Other noncurrent liabilities	**$ 5,750**	Other noncurrent liabilities	$ 1,008

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

	Location of Loss Recognized	Quarter ended March 31 2020	2019
Derivatives not designated as hedging instruments			
Interest rate swap agreements	Derivative losses	**$ (55,524)**	$ (14,652)
Foreign currency contracts	Derivative (losses) gains	**$ (21,995)**	$ 6,165

The System has used various derivative contracts in connection with certain prior obligations and investments. Although minimum credit ratings are required for counterparties, this does not eliminate the risk that a counterparty may fail to honor its obligations. Derivative contracts are subject to periodic "mark-to-market" valuations. A derivative contract may, at any time, have a positive or negative value to the System. In the event that the negative value reaches certain thresholds established in the derivative contracts, the System is required to post collateral, which could adversely affect its liquidity. At March 31, 2020 and December 31, 2019, the System posted $119.9 million and $82.4 million, respectively, of collateral with counterparties that is included in funds held by trustees in the consolidated balance sheets. In addition, if the System were to choose to terminate a derivative contract or if a derivative contract were terminated pursuant to an event of default or a termination event as described in the derivative contract, the System could be required to pay a termination payment to the counterparty.

9. Pensions and Other Postretirement Benefits

The System maintains five defined benefit pension plans, including three tax-qualified funded plans and two unfunded plans. The CCHS Retirement Plan is a tax-qualified defined benefit pension plan that provides benefits to substantially all employees of the System, except those employed by Akron General, Union Hospital or Indian River Hospital. All benefit accruals under the CCHS Retirement Plan ceased as of December 31, 2012. Martin Health System had a tax-qualified defined benefit plan covering substantially all of its employees that were hired before October 1, 2005, who met certain eligibility requirements. All benefit accruals under the Martin Health System defined benefit plan ceased as of January 1, 2013. On June 30, 2019, the Martin Health System defined benefit pension plan merged with the CCHS Retirement Plan, with the CCHS Retirement Plan being a single continuing pension plan. Akron General has a tax-qualified defined benefit plan covering substantially all of its employees that were hired before 2004 who meet certain eligibility requirements. All benefit accruals under the Akron General defined benefit plan ceased as of December 31, 2017. Indian River Hospital has a tax-qualified defined benefit plan covering substantially all of its employees that were hired before December 31, 2002 who meet certain eligibility requirements. All benefit accruals under the Indian River Hospital defined benefit plan ceased as of December 31, 2002. The benefits for the System's tax-qualified defined benefit pension plans are provided based on age, years of service, and compensation. The System's policy for its tax-qualified defined benefit pension plans is to fund at least the minimum amounts required by the Employee Retirement Income Security Act. The System maintains two unfunded, nonqualified defined benefit supplemental retirement plans, which cover certain professional staff and administrative employees.

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

9. Pensions and Other Postretirement Benefits (continued)

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

	Quarter Ended March 31	
	2020	**2019**
Amounts related to defined benefit pension plans:		
Service cost	$ (1,179)	$ (855)
Interest cost	15,951	19,393
Expected return on assets	(26,654)	(21,410)
Net amortization and deferral	(636)	(478)
Total defined benefit pension plans	(12,518)	(3,350)
Defined contribution plans	77,157	71,712
	$ 64,639	**$ 68,362**

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

As of March 31, 2020, the System has made contributions of $18.5 million to the defined benefit pension plans. The System is scheduled to make additional contributions of $6.1 million to the defined benefit pension plans for the remainder of 2020.

10. Subsequent Events

The System evaluated events and transactions occurring subsequent to March 31, 2020 through May 22, 2020, the date the consolidated financial statements were issued. During this period, there were no subsequent events requiring recognition in the consolidated financial statements, and there were no nonrecognized subsequent events requiring disclosure, except for the impact of the novel coronavirus disease pandemic on the operations of the System in 2020 and the operating lines of credit described below. Due to the evolving nature of the pandemic, the System is unable to fully determine the financial impact on its operations at this time. For additional information on the actions the System has taken as a result of the pandemic, the impact to its operations and the events and transactions that have occurred subsequent to March 31, 2020, refer to “CORONAVIRUS DISEASE (COVID-19)” in Management’s Discussion and Analysis. Also, in April and May 2020, the System obtained operating lines of credit with multiple financial institutions totaling $575 million. Each of the lines mature within one year and bear interest at LIBOR plus an applicable spread. The System has drawn $225 million on the lines of credit as of May 22, 2020 and has capacity to draw an additional $350 million if necessary.

Unaudited Consolidating Balance Sheets

($ in thousands)

	March 31, 2020				December 31, 2019			
	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	$ 333,739	$ 256,433	$ -	$ 590,172	$ 302,455	$ 203,274	$ -	$ 505,729
Patient receivables, net	1,100,641	202,270	(28,294)	1,274,617	1,139,314	195,186	(35,244)	1,299,256
Due from affiliates	22,871	74,622	(97,493)	-	44,160	10	(44,170)	-
Investments for current use	-	59,355	-	59,355	119,445	59,355	-	178,800
Other current assets	456,839	110,993	(40,139)	527,693	438,946	78,142	(28,420)	488,668
Total current assets	1,914,090	703,673	(165,926)	2,451,837	2,044,320	535,967	(107,834)	2,472,453
Investments:								
Long-term investments	7,473,380	893,092	-	8,366,472	8,155,876	1,116,411	-	9,272,287
Funds held by trustees	265,043	111	-	265,154	225,097	110	-	225,207
Assets held for self-insurance	-	119,447	-	119,447	-	157,972	-	157,972
Donor restricted assets	761,382	57,988	-	819,370	796,476	63,644	-	860,120
	8,499,805	1,070,638	-	9,570,443	9,177,449	1,338,137	-	10,515,586
Property, plant, and equipment, net	4,623,147	1,211,332	-	5,834,479	4,659,169	1,206,421	-	5,865,590
Other assets:								
Pledges receivable, net	142,704	10,663	-	153,367	143,352	11,566	-	154,918
Trusts and beneficial interests in foundations	62,977	46,020	-	108,997	67,570	45,867	-	113,437
Operating lease right-of-use assets	108,405	206,512	-	314,917	107,174	218,786	-	325,960
Other noncurrent assets	655,995	95,392	(232,423)	518,964	658,193	97,464	(229,217)	526,440
	970,081	358,587	(232,423)	1,096,245	976,289	373,683	(229,217)	1,120,755
Total assets	$ 16,007,123	$ 3,344,230	$ (398,349)	$ 18,953,004	$ 16,857,227	$ 3,454,208	$ (337,051)	$ 19,974,384

	March 31, 2020				December 31, 2019			
	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	$ 371,693	$ 86,692	$ (60)	$ 458,325	$ 431,124	$ 105,616	$ (60)	$ 536,680
Compensation and amounts withheld from payroll	423,055	65,208	-	488,263	386,325	44,596	-	430,921
Current portion of long-term debt	92,603	6,693	(72)	99,224	88,803	6,674	(72)	95,405
Variable rate debt classified as current	475,297	54,544	-	529,841	475,297	54,544	-	529,841
Due to affiliates	18,712	22,955	(41,667)	-	10	44,160	(44,170)	-
Other current liabilities	444,557	149,539	(67,029)	527,067	477,697	162,589	(66,363)	573,923
Total current liabilities	1,825,917	385,631	(108,828)	2,102,720	1,859,256	418,179	(110,665)	2,166,770
Long-term debt	3,736,652	1,067,303	(224,354)	4,579,601	3,807,383	1,115,456	(224,191)	4,698,648
Other liabilities:								
Professional and general insurance liability reserves	66,394	109,823	-	176,217	65,677	98,331	-	164,008
Accrued retirement benefits	317,171	(440)	-	316,731	329,599	17,465	-	347,064
Operating lease liabilities	84,535	202,334	-	286,869	83,326	213,342	-	296,668
Other noncurrent liabilities	555,300	103,322	(59,867)	598,755	500,478	41,688	(75)	542,091
	1,023,400	415,039	(59,867)	1,378,572	979,080	370,826	(75)	1,349,831
Total liabilities	6,585,969	1,867,973	(393,049)	8,060,893	6,645,719	1,904,461	(334,931)	8,215,249
Net assets:								
Without donor restrictions	8,369,604	1,353,311	(5,300)	9,717,615	9,115,205	1,427,771	(2,120)	10,540,856
With donor restrictions	1,051,550	122,946	-	1,174,496	1,096,303	121,976	-	1,218,279
Total net assets	9,421,154	1,476,257	(5,300)	10,892,111	10,211,508	1,549,747	(2,120)	11,759,135
Total liabilities and net assets	$ 16,007,123	$ 3,344,230	$ (398,349)	$ 18,953,004	$ 16,857,227	$ 3,454,208	$ (337,051)	$ 19,974,384

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

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

Operations

	Three Months Ended March 31, 2020				Three Months Ended March 31, 2019			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Unrestricted revenues								
Net patient service revenue	$ 2,029,517	$ 367,301	$ (64,762)	$ 2,332,056	$ 2,002,088	$ 354,984	$ (74,187)	$ 2,282,885
Other	210,432	87,774	(45,560)	252,646	195,660	82,788	(38,994)	239,454
Total unrestricted revenues	2,239,949	455,075	(110,322)	2,584,702	2,197,748	437,772	(113,181)	2,522,339
Expenses								
Salaries, wages, and benefits	1,297,350	268,715	(78,112)	1,487,953	1,243,134	251,994	(83,971)	1,411,157
Supplies	223,450	46,406	(92)	269,764	208,320	41,029	(74)	249,275
Pharmaceuticals	299,113	31,018	-	330,131	274,357	27,542	-	301,899
Purchased services and other fees	148,100	35,864	(6,706)	177,258	139,335	32,243	(7,383)	164,195
Administrative services	20,212	35,240	(5,694)	49,758	29,228	25,788	(5,428)	49,588
Facilities	70,219	21,219	(500)	90,938	73,466	22,933	(630)	95,769
Insurance	18,270	23,604	(19,193)	22,681	20,757	20,147	(15,670)	25,234
	2,076,714	462,066	(110,297)	2,428,483	1,988,597	421,676	(113,156)	2,297,117
Operating income (loss) before interest, depreciation, and amortization expenses	163,235	(6,991)	(25)	156,219	209,151	16,096	(25)	225,222
Interest	32,670	8,353	-	41,023	33,135	6,616	-	39,751
Depreciation and amortization	134,257	20,886	(25)	155,118	128,674	20,619	(25)	149,268
Operating (loss) income	(3,692)	(36,230)	-	(39,922)	47,342	(11,139)	-	36,203
Nonoperating gains and losses								
Investment return	(648,013)	(74,507)	-	(722,520)	337,243	34,397	-	371,640
Derivative (losses)	(77,091)	(428)	-	(77,519)	(8,027)	(460)	-	(8,487)
Other, net	8,185	1,169	-	9,354	235,736	193,517	-	429,253
Net nonoperating gains and losses	(716,919)	(73,766)	-	(790,685)	564,952	227,454	-	792,406
(Deficiency) excess of revenues over expenses	(720,611)	(109,996)	-	(830,607)	612,294	216,315	-	828,609

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

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

($ in thousands)

Changes in Net Assets

	Three Months Ended March 31, 2020				Three Months Ended March 31, 2019			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Changes in net assets without donor restrictions:								
(Deficiency) excess of revenues over expenses	$ (720,611)	$ (109,996)	$ -	$ (830,607)	$ 612,294	$ 216,315	$ -	$ 828,609
Donated capital	18	-	-	18	-	-	-	-
Net assets released from restriction for capital purposes	2,832	241	-	3,073	3,177	470	-	3,647
Retirement benefits adjustment	(658)	(57)	-	(715)	1,380	(57)	-	1,323
Foreign currency translation	-	3,579	-	3,579	-	457	-	457
Other	(27,182)	31,773	(3,180)	1,411	(1,640)	1,669	-	29
(Decrease) increase in net assets without donor restrictions	(745,601)	(74,460)	(3,180)	(823,241)	615,211	218,854	-	834,065
Changes in net assets with donor restrictions:								
Gifts and bequests	25,197	4,032	-	29,229	26,083	9,387	-	35,470
Net investment income	(54,793)	(1,913)	-	(56,706)	24,305	1,703	-	26,008
Net assets released from restrictions used for operations included in other unrestricted revenues	(11,502)	(1,027)	-	(12,529)	(8,473)	(615)	-	(9,088)
Net assets released from restriction for capital purposes	(2,832)	(241)	-	(3,073)	(3,177)	(470)	-	(3,647)
Change in interests in foundations	(2,158)	-	-	(2,158)	1,008	-	-	1,008
Change in value of perpetual trusts	(55)	118	-	63	(424)	(158)	-	(582)
Member substitution contribution	-	-	-	-	31,488	40,260	-	71,748
Other	1,390	1	-	1,391	8	-	-	8
(Decrease) increase in net assets with donor restrictions	(44,753)	970	-	(43,783)	70,818	50,107	-	120,925
(Decrease) increase in net assets	(790,354)	(73,490)	(3,180)	(867,024)	686,029	268,961	-	954,990
Net assets at beginning of year	10,211,508	1,549,747	(2,120)	11,759,135	8,549,594	972,413	(2,120)	9,519,887
Net assets at end of period	$ 9,421,154	$ 1,476,257	$ (5,300)	$ 10,892,111	$ 9,235,623	$ 1,241,374	$ (2,120)	$ 10,474,877

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

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Three Months Ended March 31, 2020				Three Months Ended March 31, 2019			
	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								
(Decrease) increase in total net assets	$ (790,354)	$ (73,490)	$ (3,180)	$ (867,024)	$ 686,029	$ 268,961	$ -	$ 954,990
Adjustments to reconcile (decrease) increase in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:								
Retirement benefits adjustment	658	57	-	715	(1,380)	57	-	(1,323)
Net realized and unrealized gains on investments	716,265	77,590	-	793,855	(352,087)	(32,616)	-	(384,703)
Depreciation and amortization	134,257	20,858	(25)	155,090	128,674	20,619	(25)	149,268
Foreign currency translation (gain) loss	-	(3,579)	-	(3,579)	-	(457)	-	(457)
Donated capital	(18)	-	-	(18)	-	-	-	-
Restricted gifts, bequests, investment income, and other	31,809	(2,237)	-	29,572	(50,972)	(10,932)	-	(61,904)
Transfers to (from) affiliates	25,791	(25,791)	-	-	1,632	(1,632)	-	-
Accreted interest and amortization of bond premiums	(1,541)	44	-	(1,497)	(1,509)	51	-	(1,458)
Net loss (gain) in value of derivatives	71,360	-	-	71,360	5,060	-	-	5,060
Member substitution	-	-	-	-	(266,389)	(233,766)	-	(500,155)
Changes in operating assets and liabilities:								
Patient receivables	38,673	(7,084)	(6,950)	24,639	(75,332)	(16,867)	(768)	(92,967)
Other current assets	(2,164)	(111,502)	65,042	(48,624)	(29,503)	(96,327)	80,844	(44,986)
Other noncurrent assets	873	3,157	3,231	7,261	(177,724)	(147,127)	690	(324,161)
Accounts payable and other current liabilities	(39,759)	(17,603)	1,837	(55,525)	(57,579)	29,752	(31,051)	(58,878)
Other liabilities	(12,154)	55,091	(59,792)	(16,855)	193,178	194,431	(49,152)	338,457
Net cash provided by (used in) operating activities and net nonoperating gains and losses	173,696	(84,489)	163	89,370	2,098	(25,853)	538	(23,217)
Financing activities								
Proceeds from long-term borrowings	-	163	(163)	-	2,624	538	(538)	2,624
Principal payments on long-term debt	(69,608)	(1,053)	-	(70,661)	(99,748)	(2,157)	-	(101,905)
Change in pledges receivable, trusts and interests in foundations	10,801	2,687	-	13,488	4,770	(1,496)	-	3,274
Restricted gifts, bequests, investment income, and other	(31,809)	2,237	-	(29,572)	50,972	10,932	-	61,904
Net cash (used in) provided by financing activities	(90,616)	4,034	(163)	(86,745)	(41,382)	7,817	(538)	(34,103)
Investing activities								
Expenditures for property, plant and equipment	(108,716)	(66,018)	-	(174,734)	(126,163)	(20,447)	-	(146,610)
Proceeds from sale of property, plant and equipment	1,887	-		1,887	-	-		-
Member substitution cash contributions	-	-	-	-	(1,260)	17,662	-	16,402
Net change in cash equivalents reported in long-term investments	(26,782)	154,284	-	127,502	(10,897)	29,338	-	18,441
Purchases of investments	(1,593,249)	(267,473)	-	(1,860,722)	(1,777,733)	(125,645)	-	(1,903,378)
Sales of investments	1,588,354	299,189	-	1,887,543	1,815,559	130,788	-	1,946,347
Transfers (to) from affiliates	(25,791)	25,791	-	-	(1,632)	1,632	-	-
Net cash (used in) provided by investing activities	(164,297)	145,773	-	(18,524)	(102,126)	33,328	-	(68,798)
Effect of exchange rate changes on cash	-	(16,068)		(16,068)	-	3,764		3,764
(Decrease) increase in cash, cash equivalents and restricted cash	(81,217)	49,250	-	(31,967)	(141,410)	19,056	-	(122,354)
Cash, cash equivalents and restricted cash at beginning of year	422,598	214,688	-	637,286	280,180	164,941	-	445,121
Cash, cash equivalents and restricted cash at end of period	$ 341,381	$ 263,938	$ -	$ 605,319	$ 138,770	$ 183,997	$ -	$ 322,767

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

Utilization

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

	Year Ended December 31			YTD March 31	
	2017	2018	2019	2019	2020
Total Staffed Beds[1]	3,847	4,143	4,899	4,889	4,904
Percent Occupancy[1]	70.6%	69.5%	68.1%	69.8%	67.8%
Inpatient Admissions[1]					
Acute	173,880	175,025	226,556	55,029	55,779
Post-acute	11,526	10,631	11,337	2,855	2,793
Total	185,406	185,656	237,893	57,884	58,572
Patient Days[1]					
Acute	890,353	904,854	1,098,785	276,929	272,954
Post-acute	92,449	79,999	84,465	21,471	21,415
Total	982,802	984,853	1,183,250	298,400	294,369
Average Length of Stay					
Acute	5.10	5.18	4.86	5.01	4.88
Post-acute	8.03	7.53	7.44	7.70	7.60
Surgical Facility Cases					
Inpatient	62,375	62,672	74,580	17,869	16,928
Outpatient	149,103	157,912	180,516	44,320	41,076
Total	211,478	220,584	255,096	62,189	58,004
Emergency Department Visits	644,185	675,817	883,839	219,982	217,352
Outpatient Observations	59,868	62,901	82,216	22,340	17,796
Outpatient Evaluation and Management Visits	4,991,429	5,196,809	6,373,788	1,582,730	1,531,497
Acute Medicare Case Mix Index - Health System	1.90	1.96	1.91	1.91	1.91
Acute Medicare Case Mix Index - Cleveland Clinic	2.59	2.70	2.74	2.73	2.79
Total Acute Patient Case Mix Index - Health System	1.84	1.89	1.83	1.84	1.85
Total Acute Patient Case Mix Index - Cleveland Clinic	2.52	2.63	2.65	2.63	2.67

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

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

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

Utilization (continued)

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

	Year Ended December 31			YTD March 31	
	2017	2018	2019	2019	2020
Total Staffed Beds[1]	3,352	3,477	3,986	3,976	3,991
Percent Occupancy[1]	71.8%	71.3%	70.0%	71.2%	69.3%
Inpatient Admissions[1]					
Acute	150,300	149,433	186,141	44,843	45,644
Post-acute	9,500	8,452	7,126	1,867	1,717
Total	159,800	157,885	193,267	46,710	47,361
Patient Days[1]					
Acute	778,333	788,442	928,430	231,873	229,163
Post-acute	77,908	62,913	54,515	13,892	14,427
Total	856,241	851,355	982,945	245,765	243,590
Surgical Facility Cases					
Inpatient	56,041	56,162	63,651	15,154	14,440
Outpatient	133,740	138,151	152,682	37,623	34,310
Total	189,781	194,313	216,333	52,777	48,750
Emergency Department Visits	530,384	531,812	664,987	163,617	165,080
Outpatient Observations	52,485	53,110	64,418	17,262	13,860
Outpatient Evaluation and Management Visits	4,404,070	4,676,817	5,532,283	1,369,874	1,321,144
Acute Medicare Case Mix Index	1.95	2.00	1.94	1.95	1.95
Total Acute Patient Case Mix Index	1.89	1.95	1.88	1.88	1.89

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

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

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

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:

	Year Ended December 31			YTD March 31	
	2017	2018	2019	2019	2020
Payor					
Managed Care and Commercial	38%	37%	34%	34%	34%
Medicare	46%	47%	50%	50%	50%
Medicaid	14%	14%	13%	13%	13%
Self-Pay & Other	2%	2%	3%	3%	3%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD March 31	
	2017	2018	2019	2019	2020
Payor					
Managed Care and Commercial	39%	38%	36%	36%	36%
Medicare	46%	47%	49%	49%	49%
Medicaid	13%	13%	13%	12%	13%
Self-Pay & Other	2%	2%	2%	3%	2%
Total	100%	100%	100%	100%	100%

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

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

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

Research Support

($ in thousands)

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

	Year Ended December 31			YTD March 31	
	2017	2018	2019	2019	2020
External Grants Earned					
Federal Sources	$114,942	$117,786	$120,858	$30,470	$29,668
Non-Federal Sources	92,564	105,093	104,760	23,337	24,397
Total	207,506	222,879	225,618	53,807	54,065
Internal Support	59,873	63,327	72,637	18,836	22,313
Total Sources of Support	$267,379	$286,206	$298,255	$72,643	$76,378

Key Ratios

The following table provides selected key ratios:

	Year Ended December 31			YTD March 31	
	2017	2018	2019	2019	2020
Liquidity ratios					
Days of cash on hand	383	355	373	330	337
Days of revenue in accounts receivable	49	49	49	52	50
Coverage ratios					
Cash to debt (%)	197.9	191.9	183.7	187.7	172.0
Maximum annual debt service coverage (x)	5.4	5.3	6.2	5.5	6.4
Interest expense coverage (x)	8.1	8.2	10.5	7.8	10.4
Debt to cash flow (x)	4.0	4.2	3.5	4.5	3.4
Leverage ratio					
Debt to capitalization (%)	32.5	32.9	33.6	32.2	34.9
Profitability ratios					
Operating margin (%)	3.9	3.0	3.7	1.4	(1.5)
Operating cash flow margin (%)	11.5	10.1	10.9	8.9	6.0
Excess margin (%)	12.5	1.2	16.6	25.0	(46.3)
Return on assets (%)	7.3	0.6	10.1	18.5	(17.5)

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.

Maximum annual debt service coverage is based on the Obligated Group in accordance with the master trust indenture.

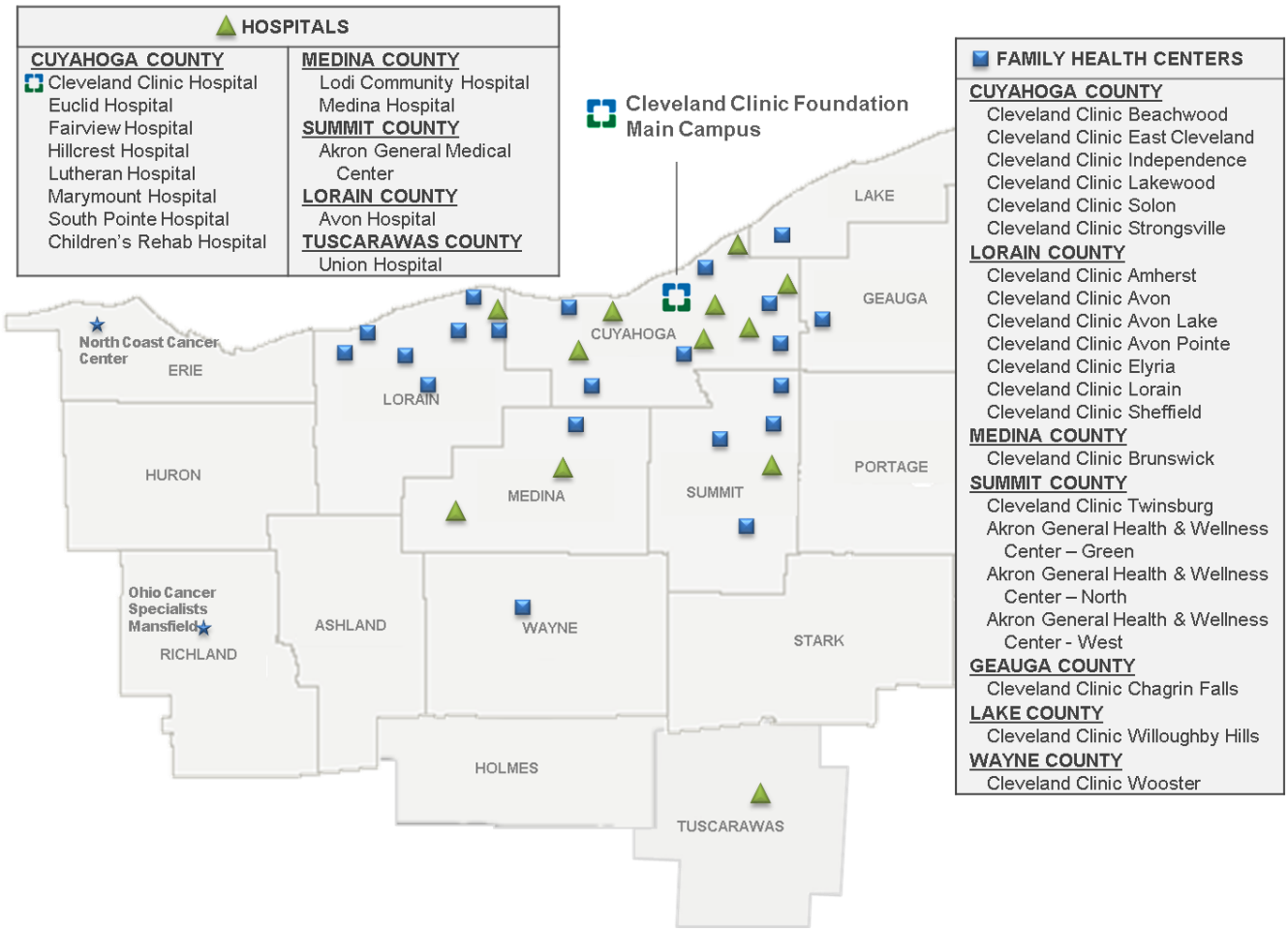
OVERVIEW

The Cleveland Clinic Health System (System) is a world-renowned provider of healthcare services that attracted patients from across the United States and from 134 other countries in 2019. As of March 31, 2020, the System operates 18 hospitals with approximately 4,900 staffed beds and is the leading provider of healthcare services in Northeast Ohio. Thirteen of the hospitals are operated in the Northeast Ohio area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates 21 outpatient family health centers, 11 ambulatory surgery centers, as well as numerous physician offices, which are located throughout Northeast Ohio, and specialized cancer centers in Sandusky and Mansfield, Ohio. In Florida, the System operates five hospitals and a clinic located throughout Southeast Florida, outpatient family health centers in Port St. Lucie, Stuart and West Palm Beach, an outpatient family health and ambulatory surgery center in Coral Springs and numerous physician offices located throughout Southeast Florida. In addition, the System operates a health and wellness center and a sports medicine clinic in Toronto, Canada and a specialized neurological clinical center in Las Vegas, Nevada. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, and Cleveland Clinic Abu Dhabi, a multispecialty hospital offering critical and acute care services that is part of Mubadala Development Company's network of healthcare facilities located in Abu Dhabi, United Arab Emirates with approximately 364 staffed beds.

Cleveland Clinic Lou Ruvo Center for Brain Health
Las Vegas, Nevada

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

CLEVELAND CLINIC HEALTH SYSTEM – NORTHEAST OHIO SERVICE AREA AND FACILITIES

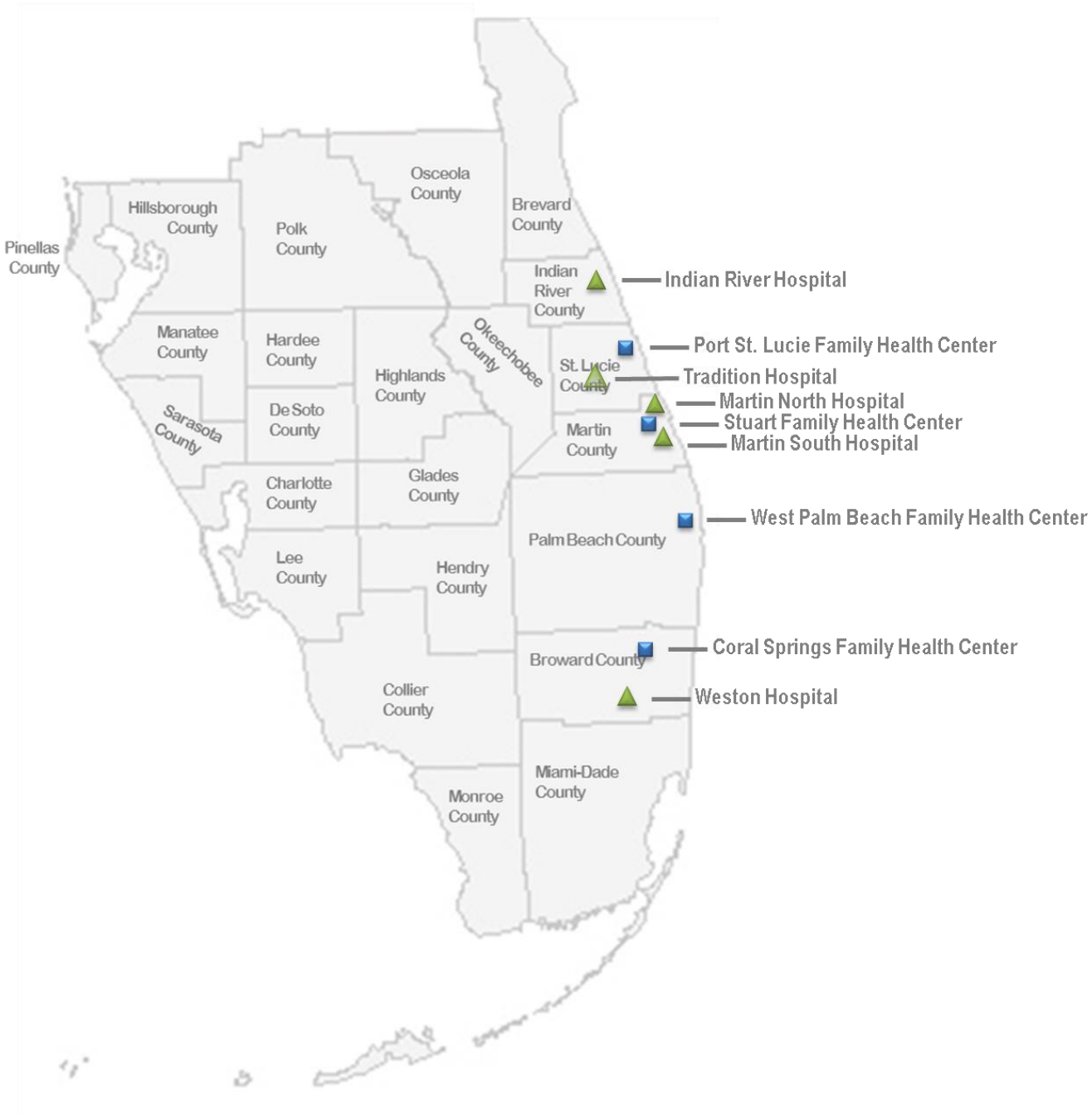


Cleveland Clinic

Every life deserves world class care.

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

CLEVELAND CLINIC HEALTH SYSTEM – SOUTHEAST FLORIDA FACILITIES



The following table sets forth the hospitals operated by the obligated issuers and their affiliates, together with each hospital's staffed bed count as of March 31, 2020:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,298
Avon Hospital	126
Euclid Hospital	166
Fairview Hospital	460
Hillcrest Hospital	440
Lutheran Hospital	194
Martin Hospital North	244
Martin Hospital South	100
Marymount Hospital	269
Medina Hospital	148
South Pointe Hospital	163
Tradition Hospital	177
Weston Hospital	206
	3,991
NON-OBLIGATED	
Akron General Medical Center	482
Children's Rehabilitation Hospital	25
Indian River Hospital	250
Lodi Hospital	20
Union Hospital	136
	913
HEALTH SYSTEM	4,904

CORONAVIRUS DISEASE (COVID-19)

Coronavirus disease (COVID-19) is an emerging, rapidly evolving health issue that is affecting the global economy and the healthcare industry. On March 11, 2020, the World Health Organization announced that the COVID-19 outbreak is a global pandemic as the rates of infection continue to rise in many locations around the world and across the United States. The Governor of Ohio declared a state of emergency related to the COVID-19 outbreak on March 9, 2020, and a national state of emergency in the U.S. was declared on March 13, 2020.

The System is working with public health partners at all levels to maintain the health and safety of patients, visitors and caregivers to prevent the spread of COVID-19. Some of the actions taken include setting up tents outside all of the emergency departments to allow for screening of potential COVID-19 symptoms and exposures prior to entering, establishing a temperature scan process for caregivers entering patient care locations, tightening its visitation policies and limiting access into all facilities. The System is also providing extensive education to patients on the precautions that have been implemented to keep patients and caregivers safe during their appointments and procedures. Patients with routine appointments are being rescheduled for telehealth visits when appropriate, and non-essential visits are being rescheduled or evaluated in accordance with government orders. The System has also revised multiple processes and policies, including requiring non-clinical employees to work from home where possible, curtailing business travel, modifying the sick leave policy, cancelling public events, and encouraging virtual meetings instead of in-person meetings.

To propel the capability for rapid testing results to help slow the spread of COVID-19, the System is establishing testing sites in its communities and partnering with other healthcare organizations to expand and expedite testing capabilities for patients. The System was one of the first health systems to offer COVID-19 testing when the pandemic began and recently surpassed 50,000 tests performed by its laboratories in Ohio and Florida. The System also partnered with Epic, its electronic health record vendor, to develop and implement a COVID-19 home monitoring program that is available for use by other healthcare organizations across the country.

On March 17, 2020, the Governor of Ohio, in collaboration with the Ohio Hospital Association, released guidelines on postponing non-essential procedures for adult and pediatric patients to support statewide efforts to conserve hospital beds, equipment and supplies while protecting healthcare workers in preparation for a potential surge of patients with COVID-19. The System immediately began to reschedule non-essential cases at its Ohio locations. Non-essential surgeries and procedures in Florida were also suspended based on orders from the Governor of Florida on March 20, 2020. The System suspended non-essential clinical activities and established COVID-19 testing locations near the System's Florida hospitals. While surgeries and procedures were suspended at its facilities, the System maintained communication with federal, state and local health officials and governmental authorities to monitor the situation and to provide insight and ideas on how to safely reactivate clinical services.

In April, the Clinic completed work to temporarily convert the main building of the Health Education Campus of Case Western Reserve University and the Clinic into a surge hospital that can be

activated if the need arises during the COVID-19 pandemic. The facility, called Hope Hospital, initially includes 327 patient beds for low-acuity COVID-19 patients with the ability to expand up to 1,000 beds if needed. The proximity of the Hope Hospital to the Clinic's main campus allows patients who need a higher level of care the ability to be quickly transferred to an intensive care unit.

On April 27, 2020, the Governor of Ohio unveiled a plan for reopening the Ohio economy beginning with allowing medical procedures and surgeries not requiring an overnight stay to resume as of May 1, 2020. In Florida, non-essential procedures were permitted on May 4, 2020. The System is working on a prudent, phased approach for reactivating its clinical services. On May 4, 2020, with the support of state government authorities, the System began reactivation of outpatient appointments, surgeries and procedures that were suspended due to COVID-19 at its Ohio and Florida locations. Several precautions have been established during this process, including COVID-19 testing for all patients three days prior to any surgery or procedure performed in an operating room or ambulatory surgery center; temperature scan and screening of patients, permitted visitors and caregivers; physical and social distancing within the facilities; requesting patients and visitors to sanitize their hands and wear a cloth mask that will be provided upon entry to the facilities; and continued extensive cleaning of all common areas. The reactivation process will focus on maintaining the highest levels of patient care and safety, while also protecting caregivers.

The operating performance of the System has been negatively impacted by COVID-19. The suspension of non-essential procedures and other scheduled appointments has adversely affected the operating revenues of the System. The System has also incurred incremental supply costs and other expenditures for COVID-19 preparedness in an effort to provide safe and effective patient care. The System experienced an operating loss of $39.9 million, or -1.5% operating margin, for the three months ending March 31, 2020, which was $76.1 million below the same period in 2019. The effect of COVID-19 on the operations of the System and the resulting negative impact on operating revenues due to the suspension of non-essential services is expected to be significant for the second quarter of 2020. Through April year-to-date, the System has experienced net patient service revenue shortfalls of over $500 million compared to plan and has incurred approximately $100 million in COVID-19 preparedness and readiness costs. These costs include equipment, labor and supplies to prepare for a surge in COVID-19 patients, obtain personal protective equipment for caregivers, establish testing capabilities and set up the Hope Hospital. Where appropriate, the System has taken measures to reduce costs and expenditures, including restricting travel, reducing purchased/administrative service expenses and other controllable costs and postponing non-critical capital expenditures. Additionally, COVID-19 has created significant volatility in the U.S and global financial markets that has resulted in investment losses in the System's investment portfolio. The System's investment portfolio experienced returns of approximately -8.7% for the three months ending March 2020. The System is continually monitoring its forecasted operating performance and liquidity position and is assessing the financial impact of COVID-19 on its operations using various scenarios and assumptions to ensure that there is sufficient liquidity during the pandemic. Due to the evolving nature of the pandemic, the System is unable to fully determine the financial impact of COVID-19 on its operations at this time.

The System has sufficient liquidity in its operating

cash accounts and within its investment portfolio to meet its obligations as they become due. At March 31, 2020, the System has 337 days of cash on hand. In April and May 2020, the System obtained operating lines of credit with multiple financial institutions totaling $575 million to further enhance its liquidity position. Each of the lines mature within one year and bear interest at LIBOR plus an applicable spread. The System has drawn $225 million on the lines of credit as of May 22, 2020 and has capacity to draw an additional $350 million if necessary.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, among other provisions, provides financial support to hospitals and healthcare providers on the front lines of the COVID-19 response. The System has received support under the CARES Act, including Centers for Medicare and Medicaid Services (CMS) accelerated and advanced payments and distributions from the Cares Act Provider Relief Fund. The CMS accelerated and advanced payment program authorizes CMS to provide advance payments during the period of a public health emergency based on certain eligibility criteria. The System received $849 million of advance payments from CMS in April. CMS can begin applying claims payments to offset the advance payments 120 days after the payment was made, and any remaining balance is required to be repaid within one year of disbursement. The System has also received $199 million from the CARES Act Provider Relief Fund in April and May. The CARES Act Provider Relief Fund provides funding from the U.S. Department of Health and Human Services (HHS) to healthcare providers to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19. Funds received under the CARES Act Provider Relief Fund represent payments to healthcare providers and do not need to be repaid as long as the System complies with certain terms and conditions imposed by HHS, including reporting and compliance requirements. The CARES Act also permits employers to defer the payment of the employer's portion of social security taxes incurred between March 27, 2020 and December 31, 2020, with half of the deferred payments required to be paid by the end of 2021 and the other half to be paid by the end of 2022. The System has deferred payroll tax payments of $29.9 million as of April 30, 2020. The System also plans to apply for funding from the Federal Emergency Management Agency (FEMA) for COVID-19 efforts. The System will continue to pursue grants and other financial assistance from CMS, HHA, and FEMA and expects to apply for any additional COVID-19 related resources made available through federal, state and local governments.

Cleveland Clinic Cancer Center
Mansfield, Ohio

AWARDS & RECOGNITION

The Clinic was ranked as the fourth best hospital in the United States by *U.S. News and World Report* in its 2019-2020 edition of "America's Best Hospitals." For the past 21 years, the Clinic has been ranked among the top five hospitals in the United States. The Clinic's Heart and Vascular Institute, located on the Clinic's main campus, was recognized as the best cardiology and heart surgery program in the United States, an honor the Clinic has received annually for 25 consecutive years. The Clinic was nationally ranked in 15 specialties, including eleven in the top ten nationwide, and is one of just 21 hospitals to earn a place on the *U.S. News'* 2019-2020 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 2019-2020 edition of "Best Children's Hospitals." The following table summarizes the Clinic's national rankings by pediatric specialty:

The publication also evaluated hospitals by state and metropolitan area with a methodology similar to that used to determine the national rankings. The Clinic was ranked as the best hospital in both the State of Ohio and the Cleveland metropolitan area, which includes the City of Cleveland and its surrounding counties. The report also ranked two additional System hospitals in the top hospitals in the Cleveland metropolitan area and Ohio: Fairview Hospital ranked third in the Cleveland metropolitan area and fourth in Ohio; and Hillcrest Hospital ranked fourth in the Cleveland metropolitan area and fifth in Ohio. Akron General Medical Center, located in Summit County, was ranked first in the Akron metropolitan area and 14th in the State of Ohio. Weston Hospital was ranked first in the Miami-Fort Lauderdale metro area and fifth in the State of Florida, and Indian River Memorial Hospital, Inc. (Indian River Hospital) ranked 27th in the State of Florida.

In March 2020, the Clinic was again named the second best hospital in the world by *Newsweek* as part of its "World's Best Hospitals 2020" analysis. *Newsweek* partnered with global research data company Statista to rank the leading hospitals in 21 countries. According to *Newsweek,* its rankings are based on three broad categories including recommendations from more than 70,000 medical experts, doctors, hospital managers, and healthcare professionals; key hospital performance indicators, including mortality rates, patient safety, readmission rates, staffing levels, efficient use of medical imaging and effectiveness and timeliness of care; and patient satisfaction data, including general satisfaction with a hospital, recommendation of a hospital, satisfaction with medical care and satisfaction with service and organizations.

For the eighth consecutive year and the tenth time in the past 12 years, Cleveland Clinic has been recognized as one of the World's Most Ethical Companies. The Clinic is one of just five healthcare providers worldwide on the 2020 list by the Ethisphere Institute, which describes itself as "advancing the standards of ethical business practices that fuel corporate character, marketplace trust and business success." The 2020 list of the World's Most Ethical Companies includes 132 organizations from 21 countries and 51 industries. The Clinic, which earned its first Ethisphere ranking in 2009, has established itself as an industry leader through its strong ethics and compliance program and a variety of innovative initiatives that demonstrate its commitment to patients, employees and the community. The World's Most Ethical Companies assessment process includes more than 200 questions on culture, diversity, governance, environmental and social practices, and ethics and compliance activities.

In April, eleven System hospitals received an "A" in the safety grades published by The Leapfrog Group, an independent national nonprofit organization that measures the quality and safety of American healthcare. The safety grade utilizes up to 28 national performance measures of publicly reported patient safety data to assign letter grades of A, B, C, D or F to over 2,600 acute care hospitals twice per year. The other System hospitals evaluated by The Leapfrog Group received a "B" safety grade.

In January 2020, the Clinic announced that the U.S. Food and Drug Administration (FDA) has cleared patient-specific airway stents developed by a Clinic physician. The stents are used to keep open the airways of patients with serious breathing disorders, such as those caused by tumors, inflammation, trauma or other masses. Standard airway stents come in a limited number of sizes and shapes and are generally designed for larger airways. The patient-specific stents are designed using CT scans and proprietary 3D visualization software to allow them to fit a patient's anatomy.

In January 2020 it was announced that the Clinic is collaborating with San Francisco based GYANT, a patient connection and relationship management company, to digitally enhance the post-discharge process and communications between a patient and their caregiver. The work started in 2018 to virtualize patient outreach to complement the Clinic's existing post-discharge call program. As part of the expanded partnership, GYANT's platform is now used in ten Cleveland Clinic hospitals.

FINANCING DEVELOPMENTS

In April and May 2020, the System obtained lines of credit with multiple financial institutions totaling $575 million. Each of the lines mature within one year and bear interest at LIBOR plus an applicable spread. The lines of credit were secured to provide additional liquidity for the System. The System has drawn $225 million on the lines of credit as of May 22, 2020 and has capacity to draw an additional $350 million if necessary.

In April 2019, Moody's affirmed its Aa2 rating on the obligated group's outstanding debt and maintained its stable outlook. Moody's cited various factors to support this rating and outlook, including a national and international clinical reputation, a leading local market position, high degree of integration and centralization, strong liquidity with sustained good operating cashflow margins and exceptional fundraising abilities. In its report, Moody's indicated that these strengths compensate for challenges such as moderately

high debt levels, execution risks of multiple strategies that require elevated capital spending, competition in the local market and Florida and constrained revenue in Northeast Ohio due to weak demographic trends.

In October 2019, S&P affirmed its AA rating on the obligated group's outstanding debt and maintained its stable outlook. S&P cited various reasons to support the rating, including a unique and very strong enterprise profile, continued focus on outpatient services and the utilization of technology to provide healthcare services and a stable leadership team that has executed at a high level on its strategic plans. S&P also noted that the System has a robust research program and one of the largest medical residency programs in the nation. Challenges to the current rating include Northeast Ohio's unfavorable demographic trends, the System's robust capital spending program and a highly competitive service area in Northeast Ohio and the growing Florida market.

CORPORATE GOVERNANCE

The Board of Directors of the Clinic is responsible for all of its operations and affairs and controls its property. The Board of Directors is also responsible for ensuring that the Clinic is organized, and at all times operated, consistent with its charitable mission and its status as an Ohio nonprofit corporation and tax-exempt charitable organization. The Board of Directors generally meets five times per year, including an annual meeting during which the Clinic's officers are elected and standing committees are appointed. The size of the Board of Directors can range between 15 to 30 Directors (currently there are 28 Directors). The Board of Trustees serves as an advisor to the Board of Directors. The Trustees actively serve on the committees of the Board of Directors. At present, there are 65 active Trustees, nine Professional Staff Trustees and 13 Emeritus Trustees. Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

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

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

The System maintains a governance model for the Ohio regional hospitals that provides for regional hospital representation on the Clinic's Board of Directors while also maintaining separate boards of trustees for each hospital. The Ohio regional hospital boards meet quarterly and, among other topics, provide local input on quality and patient safety and community health needs. Each Ohio regional hospital has a president, all of whom report to the President of Regional Hospitals and Family Health Centers.

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

Solon Family Health Center
Solon, Ohio

APPOINTMENTS

Matthew Kull was appointed Chief Information Officer (CIO) in March 2020. Mr. Kull has served as the Clinic's interim CIO since November 2019. He will continue to lead the Clinic's information technology strategy, working with clinical partners and caregivers across the System to enhance patient care through innovative technologies. Mr. Kull joined the Clinic in 2018 as the Associate Chief Information Officer of the Information Technology Division. Prior to his role at the Clinic, Mr. Kull served as Senior Vice President and Chief Information Officer for Parkland Health & Hospital System in Dallas. Mr. Kull's experience spans over 20 years in a variety of healthcare settings.

EXPANSION AND IMPROVEMENT PROJECTS

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

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

Cleveland Clinic London Hospital – In 2017, the Clinic began converting a building in London, England from office space into an eight-story, 324,000 square-foot advanced healthcare facility with approximately 184 beds and eight operating theatres that will bring the Clinic's model of care to the United Kingdom. In October 2019, the building's final external construction piece was put into place, marked by a "topping out" ceremony. For a description of the London Hospital initiative, refer to "INTERNATIONAL GROWTH." The System through a UK subsidiary entered into a private placement agreement in August 2018 to repay a term loan that was used to finance the acquisition costs and to fund a portion of the construction and conversion costs of the facility.

Neurological Institute Building – In July 2019, the Clinic announced plans to build a new Neurological Institute building on its main campus to accommodate the expansion of patient care, research and education. The new facility for the Neurological Institute is a proposed 400,000-square-foot building that will centralize all outpatient neurological care on the main campus, bringing together services currently delivered in eight locations. Services are expected to include digitized patient evaluations, imaging, neuro-simulation training, infusion therapy, neurodiagnostics and brain-mapping suites. The facility will also include research space dedicated to investigating new therapies and will serve as the nucleus for neurology-related distance healthcare and digitized data processing and management. The System is re-evaluating the timeline for this project due to the COVID-19 pandemic. A portion of the construction costs are expected to be raised through fundraising efforts and donations.

Cole Eye Institute Expansion – In July 2019, the Clinic announced plans to expand the Cole Eye Institute on its main campus to accommodate the expansion of patient care, research and education. The expansion of the Cole Eye Institute, which has grown significantly over the last 10 years, includes adding more than 100,000 square feet to the existing building to accommodate growing patient eye care and research needs. The new addition will feature an ophthalmic surgical center with operating rooms and new exam rooms, a new Center of Excellence in Ophthalmic Imaging, an expanded simulation center for education and training of residents and fellows and an ophthalmic research center to promote eye research, as well as consolidation of multiple ophthalmology research labs currently housed at different locations. The System is re-evaluating the timeline for this project due to the COVID-19 pandemic. A portion of the construction costs are expected to be raised through fundraising efforts and donations.

Mentor Hospital – In February 2019, the Clinic announced plans to build a small hospital on 47 acres of vacant land in Lake County, Ohio. The hospital will offer both inpatient and outpatient services and is expected to have an emergency department. The project is currently in the planning and design phase, and the size of the hospital and scope of services are still being determined. The System is re-evaluating the timeline for this project due to the COVID19 pandemic.

PHILANTHROPY CAMPAIGN

The Clinic is currently in the midst of "The Power of Every One" philanthropic campaign. The campaign was publicly launched in 2014 with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the Clinic to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. As of March 31, 2020, the Clinic has received pledges, cash and other assets of approximately $2.0 billion toward the goal.

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

OFFICE OF BUSINESS DEVELOPMENT

In 2019 Cleveland Clinic launched the Office of Business Development to foster and grow the strengths of Innovations and Ventures while welcoming a new function – Partnering. Together, Innovations, Ventures, and Partnering will position Cleveland Clinic not only towards its goal of being the best place to receive care but also its goal to become the best partner in healthcare.

Cleveland Clinic Innovations (CCI) grew out of the organization's deep-rooted commitment to Patients First. By focusing on domain portfolios – life science, medical device, and health information technology – and leveraging caregiver passion for medical advancement, CCI drives patient-centered solutions to market. Since its inception in 2000, CCI has transacted more than 650 technology licenses and has over 1,650 issued patents.

In 2017, Cleveland Clinic strengthened the impact Innovations makes with the creation of Cleveland Clinic Ventures (CCV). With a focus on organizational priorities as well as healthcare white space opportunities, CCV grows strategic licensed and patented solutions out of CCI into investible, standalone companies. In 2019 CCV

guided the formation of 7 new spin-off companies while overseeing the investment of over $10 million across 10 companies. Together they have formed a total of 92 spin-off companies, 43 of which are currently operational with 23 monetized.

Recognizing that meaningful change and impact come with collaboration, the complement of strengths within CCI and CCV was rounded out in 2019 with the formation of Partnering. By combining brand strength and internal capabilities with those of strategic external stakeholders, Partnering accelerates the deployment of patient-benefitting technologies through opportunities in co-development, co-investment, and shared risk and returns while creating diversification in the organization's revenue stream. In 2019 the Clinic launched its digital transformation strategy as a cornerstone to doubling the number of patients served. The first initiative, a joint venture with the prominent telehealth company American Well, exemplifies how the Clinic and its partners will transform the business of healthcare.

The Office of Business Development hosts an annual Medical Innovation Summit in downtown Cleveland for industry leaders, investors and entrepreneurs looking to expand their understanding of the healthcare market and the future of medical innovation. The October 2019 summit, *Caring for Every Life through Innovation,* tackled digital transformation, investment trends, non-traditional entrants, and consumerization in healthcare while keeping the patient at the forefront of the conversation. The Summit reflects the combined strategies of Innovations, Ventures, and Partnering while showcasing how their collaborative work embraces and drives forward the Clinic's mission to provide better care of the sick and investigation into their problems.

The Clinic also hosted the 2019 Value-Based Innovation Summit (Best Practices in an Accountable World) and the 2019 Nursing Innovation Summit (Inspiration, Cultivation, Collaboration), which ran concurrently with the 2019 Medical Innovation Summit. Collectively, these summits brought together clinical, financial and global benefit thought leaders from around the world for a discussion of best practices and solutions in value-based care and other forms of medical innovation. The Clinic also released its Top 10 Medical Innovations for 2020, which highlights the potential for medical breakthroughs in the coming year. The "Top 10" has been led by Cleveland Clinic Innovations since its debut in 2007. Each year, Cleveland Clinic Innovations interviews over 75 Clinic experts to elicit more than 150 nominations, which are presented, debated and ranked in a series by two separate committees of clinical experts that vote on the combined lists to establish the Top 10 Medical Innovations.

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

CLINICAL AFFILIATIONS

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

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

The System worked with Epic to develop and implement a COVID-19 home monitoring program that is now available for use by other healthcare organizations across the country. Collaboration among clinicians and analysts helped the System and Epic to rapidly design, build and launch the technology in just ten days. The System and Epic used Epic's MyChart Care Companion to monitor patients with chronic conditions and customized it for COVID-19. Patients complete questions about their symptoms daily so primary care teams can monitor their conditions and react quickly if patients worsen.

The tool also allows patients to engage with a member of their care team to manage their progress and recovery. Patients also can access education, condition-tracking and treatment information through the tool's app. All patient information from the remote monitoring is stored in the Electronic Health Record (EHR), and the system integrates population management tools to generate reports and a patient registry to track outreach and encounters with clinicians.

Daily monitoring, which continues for 14 days from the reported onset of symptoms, includes a Care Companion task reminder and telephone outreach to high-risk patients from a registered nurse or allied health professional. Patients enrolled after a hospital stay are monitored for seven days after discharge. Through the EHR, patients' primary care and other providers are kept informed about all encounters.

The information collected through these touch points is stored in the EHR, and discrete data collection enables further research and predictive modeling in the ongoing efforts to better understand and treat COVID-19.

AKRON GENERAL HEALTH SYSTEM

The Clinic became the sole member of Akron General Health System (Akron General) in November 2015. During the operational integration process in early 2016, a compliance review conducted by the System of contractual relationships between Akron General and its independent physician practice groups identified a group of physician arrangements that were potentially non-compliant with the Federal Anti-Kickback Statute and the Limitations on Certain Physician Referrals regulation (commonly referred to as the Stark Law). Any noncompliance may have resulted in false claims to federal and/or state healthcare programs beginning in 2010 and could result in liability of Akron General under the Federal Anti-Kickback Statute, Stark Law, False Claims Act and/or other laws and regulations. The System voluntarily disclosed its concerns about these physician arrangements to the U.S. Department of Justice (DOJ) in May 2016. Akron General and the System have produced information to, engaged in discussions with, and are cooperating with the DOJ and related government authorities in connection with this matter.

Corrective actions have been taken by Akron General related to all of the physician arrangements at issue, and the Clinic has implemented its compliance programs at Akron General. Discussions with the DOJ and related government authorities about the physician arrangements are ongoing, though a timeframe for completion of the inquiry by the government authorities that may arise under the Federal Anti-

Kickback Statute, Stark Law, False Claims Act and/or other related laws and regulations cannot be estimated at this time. The outcome of the ongoing dialogue with the DOJ is not expected to be material to the System or negatively impact the operations and/or financial condition of Akron General and/or the System.

MERCY MEDICAL CENTER

The Clinic announced that it executed a non-binding letter of intent with the Sisters of Charity Health System on September 27, 2019 to explore adding Mercy Medical Center to the System. Mercy Medical Center is a 476 licensed bed hospital serving Stark, Carroll, Wayne, Holmes and Tuscarawas counties and parts of southeastern Ohio. Benefits of the potential partnership could include expanding high-quality services; expanding and improving technology at Mercy Medical Center; providing additional support and investment in addressing the unmet needs in the community; building physician synergies; and increasing the ease of access to the most highly specialized services for patients in Stark County and the surrounding communities. The execution of the letter of intent begins the review and due diligence process for the Clinic and Sisters of Charity Health System. No assurances can be given at this time that this process will lead to the execution of a definitive agreement between the parties or Mercy Medical Center actually joining the System.

FLORIDA GROWTH

In January 2019, the Clinic through a subsidiary became the sole member of Martin Health System, located in Southeast Florida, approximately 100 miles north of Weston. Martin Health System is a regional not-for-profit, community-based healthcare provider consisting of three licensed acute-care hospitals with approximately 521 licensed beds, an approximately 140-member employed physician group and a network of outpatient services. As part of the agreement, the Clinic committed to invest at least $500 million into Martin Health System over five years to support strategic and capital needs, as well as other programs and services. The Clinic also will maintain certain clinical services at each of the Martin Health System hospitals for at least ten years. Martin Memorial Medical Center, a subsidiary of Martin Health System, became a member of the Obligated Group in May 2019.

In January 2019, the Clinic through a subsidiary became the sole member of Indian River Hospital, located in Southeast Florida approximately 130 miles north of Weston. Indian River Hospital is a not-for-profit medical center with approximately 332 licensed beds and is focused on providing healthcare to Indian River and surrounding counties in Florida. Under the terms of the transaction, the Clinic committed to invest at least $250 million in Indian River Hospital over the next decade and will maintain certain clinical services at Indian River Hospital for at least ten years. Indian River Hospital will continue to lease the hospital facilities and the land on which they stand under an amended and restated agreement with the Indian River County Hospital District for a term of up to 75 years.

Since the completion of the affiliations with Martin Health System and Indian River Hospital in January 2019, the services, programs and

locations managed and operated by Martin Health System and Indian River Hospital are being integrated into and/or aligned with the Health System and their operations and procedures examined to look for opportunities to improve the quality and delivery of care.

INTERNATIONAL GROWTH

In October 2015, the Clinic through a subsidiary acquired all of the share capital of 33 Grosvenor Place Limited (Grosvenor Place). Grosvenor Place is a limited liability company existing under Luxembourg law and a private company incorporated under Jersey law that has a long-term leasehold interest in a building in London, England. In January 2017, regulatory approvals were received to convert the building from office space into an approximately 184-bed hospital that will bring the Clinic's model of care to the United Kingdom. For a description of the London hospital project, refer to "EXPANSION AND IMPROVEMENT PROJECTS." A Chief Executive Officer for Cleveland Clinic London was appointed in 2018, and senior leadership positions have been filled. The local leadership team is in the process of connecting with local physicians and third-party payors, recruiting additional staff and finalizing operational strategies in preparation for seeing the first patient.

In addition to the London project, the System operates a health and wellness center and a sports medicine clinic in Toronto, Canada, and provides management services to Cleveland Clinic Abu Dhabi, a multispecialty 364-staffed bed hospital offering critical and acute care services that opened in March 2015.

In April 2019, Cleveland Clinic Abu Dhabi broke ground on a new seven-story cancer treatment center that will be constructed adjacent to the existing hospital tower. The center is due to open in 2022 and will be modeled after the Clinic's Taussig Cancer Center. The facility will expand the range of cancer treatments available and will centralize oncology services by providing dedicated clinical practice areas for advanced imaging, infusion, radiation, and chemotherapy, as well as a connection to the hospital's surgical areas.

Cleveland Clinic Glickman Tower
Cleveland, Ohio

In 2017, the Clinic established Cleveland Clinic Connected, a global affiliation program that aims to improve patient care delivery around the world by enabling international healthcare providers to access the Clinic's best practices. The Clinic entered into its first Cleveland Clinic Connected relationship with Luye Medical Group to collaborate on the development of Shanghai Luye Lilan Hospital in the Shanghai New Hong Qiao International Medical Center currently under construction in Shanghai, China. The hospital, which will be owned and operated by Luye Medical Group, is expected to open in 2024. Patients will experience the Clinic model of care through the Clinic's collaboration and guidance in the areas of quality, patient safety and best practices for patient care and engagement. Patients at the facilities have the option of receiving distance health and second opinions from the Clinic, and physicians at the facilities have access to clinical and executive education opportunities aimed at improving healthcare delivery. The Clinic will also support continuous improvement through the provision of advisory services across a spectrum of clinical and non-clinical areas.

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

STRATEGY

The COVID-19 pandemic in 2020 has been a rapidly evolving situation that has significantly affected the global economy and the healthcare industry. The System continues to monitor the situation and remains committed to providing exceptional patient care while ensuring the safety of its patients, visitors and caregivers. In the uncertainty of the pandemic, the System maintains its mission to provide better care for the sick, investigate their problems and furtherer educate those who serve. Refer to "CORONAVIRUS DISEASE (COVID-19) for information on the System's current efforts and strategies related to COVID-19.

The U.S. healthcare industry continues to undergo dramatic change with the intersection of economic pressure, insurance reform, technological breakthroughs and demographic shifts. At the center of this change is a shift in reimbursement models from fee for service to value-based and risk-based payments. This ongoing payment shift is occurring both in commercial and government payer segments, requiring healthcare delivery organizations to rethink fundamental capabilities for managing care. Contributing to the reformation of healthcare is a new level of consumerism spurred by the continued growth of high-deductible health insurance products and expectations for transparency, customization, and on-demand solutions. As these changes take place, the combination of consolidation, a blurring of traditional roles, and new entrants with innovative business models and compelling customer value propositions are reordering the healthcare landscape.

The System has set forth a strategy that embraces these fundamental shifts and positions the organization for continued leadership and success in advancing its mission and meeting its goals in an uncertain and vastly changing healthcare environment. Anchoring the strategy is the System's belief that modern not-for-profit healthcare organizations must tend to four fundamental needs: care for the patients; care for the caregivers; care for the organization; and care for the community.

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

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

Care Resource Optimization - Develop a sustainable cost position.

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

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

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

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

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

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

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

Technology - Develop an industry leading digital and analytics platform.

In 2017, the System launched Cleveland Clinic Community Care, an institute created to better enable healthcare providers and teams to take care of patient populations. Cleveland Clinic Community Care is designed to bring primary care providers together under one umbrella – internal medicine, family medicine, hospital medicine, general pediatrics, wellness, home care and Express Care all report to the same unit. Primary care physicians are joined by advanced practice providers and medical assistants, who are supported by nurses, patient service representatives and care coordinators, working together to meet the needs of a specific group, or panel of patients. This single integrated care model brings together caregivers from primary and specialty care institutes and community providers in managing local populations and delivering community-based primary and chronic care. The model leverages data and an expanded care team to proactively address the health needs of populations.

As a major element of delivering value, an important thread through all of the priority initiatives of the clinical enterprise is Care Resource Optimization – developing a sustainable cost position given factors such as economic pressure and insurance reform impacting the healthcare industry. In 2013, the System performed an enterprise-wide cost structure analysis and proposed recommendations for transformational cost and efficiency opportunities. The System is structured to continually monitor its use of resources in all clinical, operational and administrative areas. Since the inception of the program in 2014, management estimates that Care Resource Optimization initiatives and other localized efforts enabled more than $1 billion of improvements in the cost structure. The System continues to develop and implement cost management and containment plans for a more affordable care model and to enable investments in key strategic initiatives. This work is expected to be an ongoing effort.

In parallel with efforts to transform the care model, the System is redefining its relationships with payors and the payment system to match the broader industry trend toward value-based contracting. The System continues to explore increased forms of risk-taking in payer contracts including pay-for-performance, bundled payments, global risk contracts and narrow network arrangements with payer partners. The System has implemented various risk contracting initiatives, including the co-branded insurance products with payer partners launched in 2018 that focus on specific product and consumer segments.

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

Over the past several years, the System has pursued digitalization of care through virtual visit and telemedicine programs. Telehealth medicine has become increasingly important during the

COVID-19 pandemic to ensure the safety of patients that do not need to travel to System facilities and to prevent the spread of COVID-19. These programs are being used to deploy distance health capabilities to more systematically connect physicians, patients and health systems to extend patient access, improve experience, increase efficiency and explore new care delivery models. Patient access initiatives are focused on providing lower cost, efficient care alternatives for lower acuity medical conditions to System patients. In 2019, the System provided over 58,000 virtual visits. Due to the shift in patient appointments from in-person to telehealth as a result of COVID-19, the System had over 200,000 virtual visits in April 2020.

Caregivers throughout the System continue to identify and pursue ways to improve on every dimension of the organization's performance: relentless pursuit of quality and safety; organization and delivery of care; effectuation of research and education; and the clearly conveyed message of the System's value to the community. 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

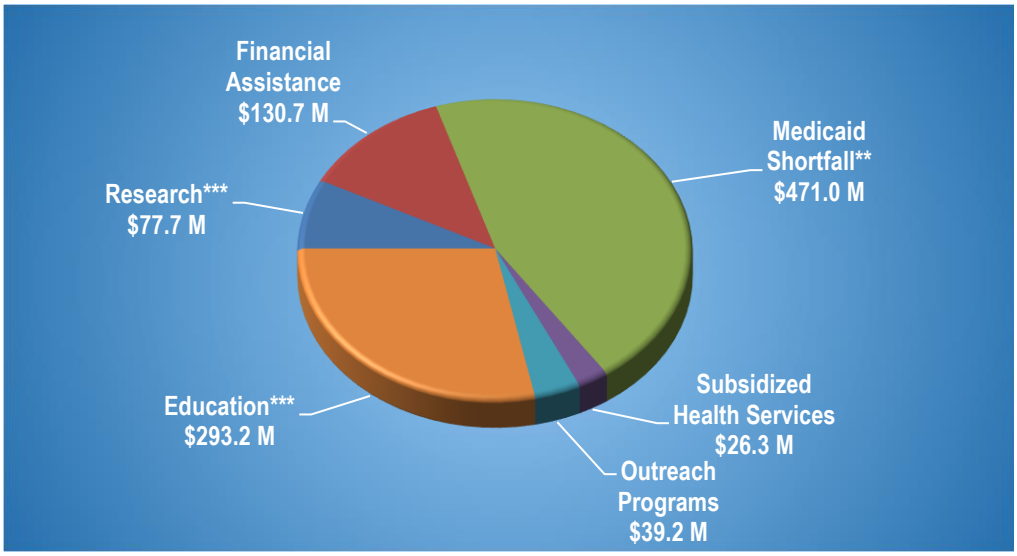
Community Benefit

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 2018, the System provided $1.04 billion in benefits to the communities it serves. Community benefit information for 2019 was not available at the time of issuance of this Management Discussion and Analysis. The following chart summarizes community benefits for the System:

Cleveland Clinic Health System*
Breakdown of Community Benefit (2018)
$1.04 Billion



* Includes all System operations in Ohio, Nevada and Florida, including the fiscal year 2018 activity of Martin Health System and Indian River Hospital

** Includes net Hospital Care Assurance Program assessment of $6.2 million

*** Research and Education are reported net of externally sponsored funding of $170.7 million.

Financial Assistance: Financial Assistance represents the cost of providing free or discounted medically necessary care to patients unable to pay some or all of their medical bills. The System's financial assistance policy provides free or discounted care to uninsured patients with incomes up to 400 percent of the federal poverty level and who meet certain other eligibility criteria by state. This policy covers both hospital care and services provided by the System's employed physicians.

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

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

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

- The System provided no-cost clinical care to under- and uninsured families at community sites. For example, the Langston Hughes Health and Education Center, a Fairfax neighborhood site, provided multigenerational wellness classes, cancer screening and chronic disease management 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 and finding a medical home.
- Wellness initiatives and community education classes were provided to schools, faith-based organizations and community centers in the areas of prevention, chronic disease management and behavioral change, including tobacco cessation, weight management, teen parenting, family violence and child safety.
- Collaborative initiatives with community nonprofits and local governments addressed critical population issues. Taskforce strategies focused on decreasing opioid prescription use and overdose deaths. Hospitals and counties explored methods to decrease infant mortality including proactive centering programs and community baby showers.
- Physical education, training and concussion awareness were provided to high school students by the Clinic's Orthopedic and Rheumatology Institute. Community pediatrics provided wellness services to local schools and professional support to students affected by trauma.
- Workforce development programs were provided to middle school and high school students to enhance graduation rates, pursue secondary education and obtain employment.
- The Clinic's Robert J. Tomsich Pathology & Laboratory Medicine Institute and Cole Eye Institute donated services to community organizations.

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

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

Community Health Needs Assessment

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

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

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

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

Key CHNA needs identified throughout the System include:

- access to affordable healthcare;
- addiction and mental health;
- chronic disease prevention and management (heart disease, cancer, diabetes, asthma, obesity);
- infant mortality;
- medical research;
- education (physician shortage); and
- socioeconomic concerns

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

Economic Impact

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

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

SUSTAINABILITY

The System supports healthy environments for healthy communities, recognizes the link between environmental and human health and strives to responsibly address and mitigate its environmental impacts. As a national leader in healthcare, the System is in a position to lead by example in the adoption of environmental best practices.

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

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

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

improving patient safety and care through tools, best practices and knowledge. In 2019, the Clinic won the Top 25 Environmental Excellence Award for the fifth straight year. This award recognizes healthcare facilities that exemplify environmental excellence and are setting the highest standards for environmental practices in healthcare. Award winners are chosen from hospitals that have the highest scores using Practice Greenhealth's thorough scoring and evaluation system. The Clinic was also recognized for being in the top ten in the nation in four Circles of Excellence: Climate, Energy, Green Building and Greening the OR. Other System entities and facilities were honored in 2019 with additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in healthcare sustainability.

The System's energy program is designed to enhance patient outcomes and the patient experience while reducing operating expenses. As the model of healthcare evolves, the System is committed to reducing environmental, economic and human impact by reducing energy intensity. The System's commitments to both affordable care and external partnerships with ENERGY STAR and the Better Buildings Challenge have created goals of becoming 20% more energy efficient by 2020 from a 2010 baseline on more than 20 million square feet of facilities. Initiatives include a combination of critical energy efficiency projects and broad occupant education and engagement campaigns. From the December 2010 baseline, the System has realized a 22.2% reduction in weather normalized source energy use intensity for in-scope and reportable facilities.

In December 2019, the Clinic was awarded the Ohio Environmental Protection Agency (EPA) platinum level environmental stewardship award, which is the highest recognition available for environmental excellence. The Clinic earned this award for its emphasis on recycling, energy demand reduction, green infrastructure and work to create environmental improvements throughout the community. To earn the platinum award, a business or organization must expand their environmental program beyond their facilities and demonstrate how their environmental stewardship efforts benefit the local community, region or larger geographic area.

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

The System currently has 17 LEED-certified buildings, with one additional building pending certification. The System has five buildings that are certified LEED-Gold, including the Global Cardiovascular Innovations Center, Marymount Hospital Surgical Expansion, Twinsburg Family Health and Surgery Center, the Tomsich Pathology Laboratories building and the Sheila and Eric Samson Pavilion at Health Education Campus.

In 2018, the Clinic's Center for Functional Medicine suite located on the Clinic's main campus achieved WELL certification, a new building standard that integrates human health into building design and operation. The WELL Certification process involves rigorous testing and a final evaluation carried out by the Green Business Certification Inc., which is the third-party certification body for the WELL Building

Standard. WELL certification focuses on seven main concepts: air quality, water quality, healthy foods, light quality, integration of fitness, comfortable and productive workspaces, cognitive and emotional health and support for innovative features that impact the interaction between building and human health. The Center for Functional Medicine is one of the first medical offices to be awarded this certification.

DIVERSITY

The System provides healthcare services to patients and families from a global community. The Office of Diversity and Inclusion (ODI), created in 2006, makes diversity, inclusion and cultural competence a critical part of the System's mission with a goal of creating a culture where caregivers integrate diversity and inclusion throughout the enterprise. In 2019, inclusion was added as a core value of the System. ODI maintains a strategic direction to build cultural competence, cultivate an inclusive organization, promote safety, quality, innovation, and health equity, develop talent, and support a diverse population of caregivers and patients. Its programs include cultural competence training, diversity councils, employee resource groups (ERG), language enrichment, consultation and pipeline development programs.

The System was recognized as a "2019 Top Performer in LGBTQ Healthcare Equality," by the Human Rights Campaign. This distinction is based on the results of the campaign's Health Equality Index, which scores healthcare facilities on policies and practices dedicated to the equitable treatment and inclusion of LGBTQ patients, visitors, and employees.

The SALUD ERG sponsored program, ACTiVHOS™, received financial support and approval for ongoing expansion into 2020. ACTiVHOS™ stands for "Activity, Cognitive Therapy, and Incentives in Health Outreach for Students" and is the first and only bilingual/bi-cultural youth wellness program in Northeast Ohio. It was started by SALUD, the System's Hispanic/Latino ERG with support from ODI.

In May 2019, the Clinic was awarded the 2019 Best in Class Award in the category of "Workforce Diversity" by the Greater Cleveland Partnership. The Partnership's Commission on Economic Inclusion works with Northeast Ohio employers to make diversity a source of economic strength. The Clinic was selected from more than 100 organizations for the award, which was based on an assessment that measured the strategy and development of inclusion initiatives at the Clinic in comparison to other businesses of similar size and type.

For the third year in a row, Forbes named the Clinic among America's Best Employers for Diversity for 2020. In order to determine the rankings Forbes surveyed 60,000 Americans working for businesses with at least 1,000 employees. Participants were asked to share their opinions and rate their organizations on age, gender, ethnicity, disability, sexual orientation, equality, general diversity and other criteria. The results ranked 500 employers based on the employers that received the most recommendations while also considering employers that have diverse boards and executive teams as well as proactive diversity and inclusion initiatives.

For the 11th year in a row, DiversityInc named the Clinic to its 2020 list of Top Hospitals & Health Systems in the country for diversity, equity and inclusions. This year the Clinic ranked third on

the list. The Clinic has made the rankings each year since the list for healthcare organizations began in 2010. The Rankings are empirically driven and assess performance based on a number of factors including talent pipeline, talent development, leadership accountability and supplier diversity.

CONFLICT OF INTEREST

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

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

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

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

ENTERPRISE RISK MANAGEMENT

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

In the ERM process, risk identification is conducted resulting in a System risk profile that categorizes individual risks based on their impact upon the System's ability to meet its strategic objectives. During this process, certain risks are identified as top risks and then further separated into sub-risks and individual risk components. Extensive risk assessments and mitigation analyses have been prepared 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 second quarter of 2019. 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 2019, which is the eleventh year the management report was completed. As part of the internal control evaluation process for 2019, certifications were completed by 145 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. There were no changes in internal controls over financial reporting during the three months ended March 31, 2020 that have materially affected, or are likely to materially affect, the internal controls over financial reporting for the System.

INDUSTRY OUTLOOK

In March 2020, Moody's changed its outlook for nonprofit hospitals from stable to negative primarily due to how the COVID-19 outbreak is expected to affect cash flows and the widespread uncertainty associated with the pandemic. Previous estimates of 2-3% cash flow growth are not expected to occur, and Moody's believes nonprofit hospitals will likely see lower cash flow and declining operating revenues compared to 2019 as elective surgeries and procedures are cancelled or postponed.

In March 2020, S&P changed its outlook for the U.S not-for-profit healthcare sector from stable to negative due to the increasing threat of the COVID-19 pandemic. S&P anticipates the pandemic will result in increased operating costs, reduced volume and revenues, reliance on working capital lines of credit, and decreased unrestricted reserves and nonoperating revenue. Recent investment market deterioration may also pressure the credit quality of many organizations.

PATIENTS SERVED

The following table summarizes patient utilization statistics for the System:

Utilization Statistics

	For the quarter ended March 31			
	2020	2019	Variance	%
Inpatient admissions[(1)]				
Acute admissions	55,779	55,029	750	1.4%
Post-acute admissions	2,793	2,855	-62	-2.2%
	58,572	57,884	688	1.2%
Patient days[(1)]				
Acute patient days	272,954	276,929	-3,975	-1.4%
Post-acute patient days	21,415	21,471	-56	-0.3%
	294,369	298,400	-4,031	-1.4%
Surgical cases				
Inpatient	16,928	17,869	-941	-5.3%
Outpatient	41,076	44,320	-3,244	-7.3%
	58,004	62,189	-4,185	-6.7%
Emergency department visits	217,352	219,982	-2,630	-1.2%
Observations	17,796	22,340	-4,544	-20.3%
Clinic outpatient evaluation and management visits	1,531,497	1,582,730	-51,233	-3.2%

[(1)] Excludes newborns

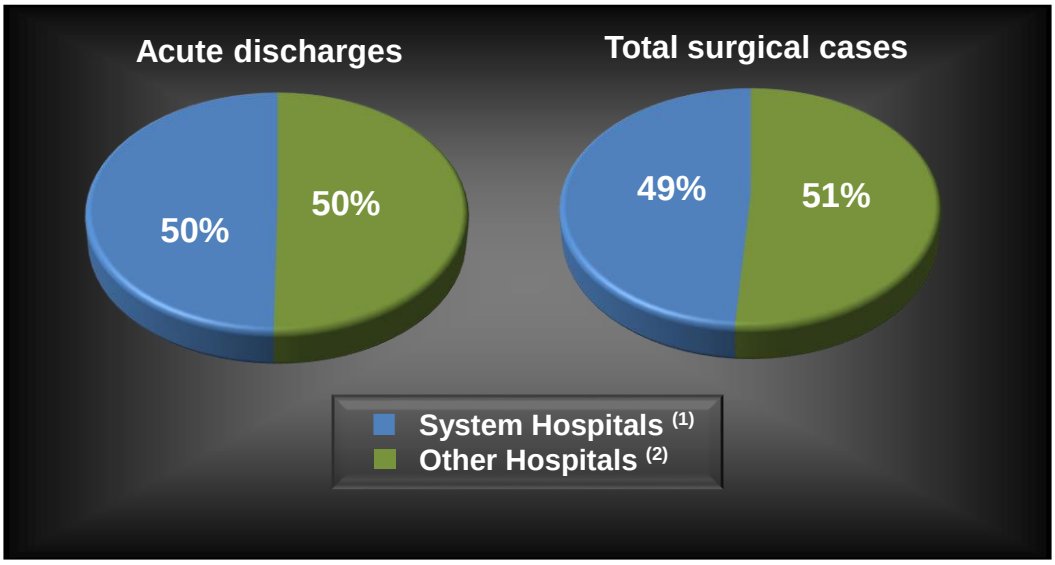
Patients served for the System in the first quarter of 2020 has been significantly impacted by the suspension of non-essential procedures and appointments in mid-March. Non-essential procedures and appointments were suspended through May 4, 2020 in an effort to prevent the spread of COVID-19 and to provide for capacity at the System's facilities for a potential surge of COVID-19 patients. With the support of state governments, the System has begun the reactivation process for certain clinical services using a prudent, phased approach to protect patients and caregivers and maintain the highest levels of patient care and safety.

Inpatient acute admissions for the System increased 1.4% in the first quarter of 2020 compared to the same period in 2019. In the first quarter of 2020, acute admissions for the System in Ohio increased 2.2% compared to the same

period in 2019, while the Florida facilities experienced a 1.2% decrease in acute admissions over the same period.

Total surgical cases for the System decreased 6.7% in the first quarter of 2020 compared to the same period in 2019. In the first quarter of 2020, total surgical cases for the System in Ohio decreased 7.0%, while the Florida facilities decreased 5.8%.

The following charts summarize selected statistical information for Cleveland metropolitan hospitals for the three months ended March 31, 2020:



Source: The Center for Health Affairs Volume Statistics

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

LIQUIDITY

Cash and Investments

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

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

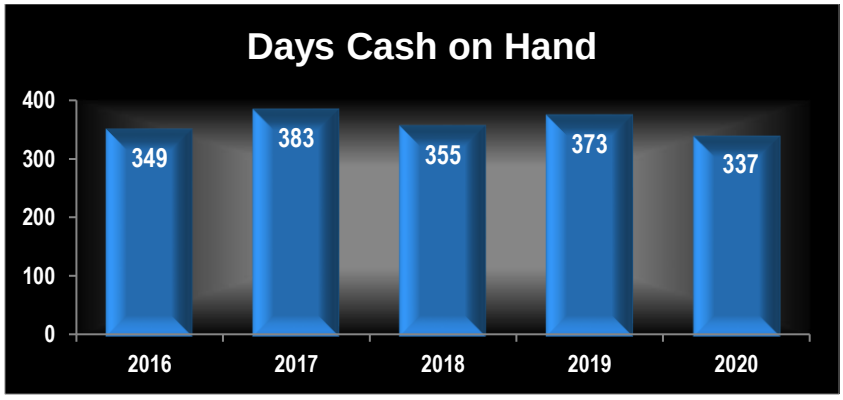
The following table sets forth the allocation of the System's cash and investments in its general investment portfolios and captive insurance fund at March 31, 2020 and December 31, 2019:

Cash and Investments
(Dollars in thousands)

	March 31, 2020		December 31, 2019	
Cash and cash equivalents	$ 1,639,260	16%	$ 1,795,801	16%
Fixed income securities*	2,789,390	27%	2,907,668	26%
Marketable equity securities*	2,156,561	21%	2,865,852	26%
Alternative investments	3,634,759	36%	3,630,794	32%
Total cash and investments	$ 10,219,970	100%	$ 11,200,115	100%
Less restricted investments**	(1,263,326)		(1,422,099)	
Unrestricted cash and investments	$ 8,956,644		$ 9,778,016	
Days cash on hand	337		373	

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

The following chart summarizes days cash on hand for the System at December 31 for the last four years and at March 31, 2020:



At March 31, 2020, total cash and investments for the System (including restricted investments) were $10.2 billion, a decrease of approximately $1.0 billion from $11.2 billion at December 31, 2019. Cash inflows consist of cash provided by operating activities of $89.4 million. Cash inflows were offset by net investment losses of $794.8 million, capital expenditures of $172.8 million, principal payments on debt of 70.7 million, a net decrease in restricted gifts and income of $16.1 million, and foreign exchange losses on cash and cash equivalents of $16.1 million. Days cash on hand for the System for the first quarter of 2020 was negatively impacted by investment losses.

Included in the System's cash and investments are investments held for self-insurance. These investments totaled $178.8 million at March 31, 2020, with an asset mix of 7% cash and short-term investments, 35% fixed-income securities, 29% equity investments and 29% alternative investments. The asset mix reflects the need for liquidity and the objective to maintain stable returns utilizing a lower tolerance for risk and volatility consistent with insurance regulatory requirements.

Also included in the System's cash and investments at March 31, 2020 are $265.2 million of funds held by trustees. Funds held by trustees include $126.2 million of posted collateral. Collateral is primarily comprised of $5.4 million related to a futures and options program within the System's investment portfolio and $119.9 million related to the System's interest rate swap contracts. The swap contracts require that collateral be posted when the market value of a contract in a liability position exceeds a certain threshold. The collateral is returned as the liability is reduced. Investment objectives of funds held by the trustees are designed to preserve principal by investing in highly liquid cash or fixed-income investments. At March 31, 2020, the asset mix of funds held by trustees was 57% cash and short-term investments and 43% fixed-income securities.

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

Alternative investments at March 31, 2020 and December 31, 2019 consist of the following:

Alternative Investments
(Dollars in thousands)

	March 31, 2020		December 31, 2019	
Hedge funds	$ 2,006,501	55%	$ 2,071,318	57%
Private equity/venture capital	1,336,878	37%	1,259,139	35%
Real estate	291,380	8%	300,337	8%
Total alternative investments	$ 3,634,759	100%	$ 3,630,794	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 interest and dividends earned on assets held by the captive insurance subsidiary, which are included in other unrestricted revenues. Donor restricted investment return on restricted investments is included in net assets with donor restrictions.

The System's long term investment portfolio, which excludes assets held for self-insurance, reported investment losses of approximately 8.7% for the first quarter of 2020 compared to gains of 4.8% in the first quarter of 2019.

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

Investment Return
(Dollars in thousands)

	For the quarter ended March 31	
	2020	2019
Other unrestricted revenue:		
Interest income and dividends	$ 394	$ 490
Nonoperating gains and losses, net:		
Interest income and dividends	19,333	17,945
Net realized gains (losses) on sales of investments	118,822	49,470
Net change in unrealized gains (losses) on investments	(715,536)	278,420
Equity method income on alternative investments	(138,591)	32,464
Investment management fees	(6,548)	(6,659)
	(722,520)	371,640
Other changes in net assets:		
Investment income on restricted investments	(56,706)	26,008
Total investment return	$ (778,832)	$ 398,138

Operating Lines of Credit

In April and May 2020, the System obtained lines of credit with multiple financial institutions totaling $575 million. Each of the lines mature within one year and bear interest at LIBOR plus an applicable spread. The lines of credit were secured to provide additional liquidity for the System. The System has drawn $225 million on the lines of credit as of May 22, 2020 and has capacity to draw an additional $350 million if necessary.

Long-term Debt

At March 31, 2020, outstanding current and long-term debt for the System excluding unamortized premium and unamortized debt issuance costs totaled $5.1 billion, comprised of $5.0 billion in bonds and notes and $116 million in finance leases. Bonds and notes are structured with approximately 77% fixed-rate debt and 23% variable-rate debt. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds. The total notional amount on the System's interest rate swap contracts at March 31, 2020 was $602.8 million. Using an interest rate benchmark, these contracts convert variable-rate debt to a fixed-rate, which further reduces the System's exposure to variable interest rates. The interest rate swap contracts can be unwound by the System at any time, whereas the counterparty has the option to unwind the contracts only upon an event of default as defined in the contracts.

As of March 31, 2020, approximately $607 million of variable-rate debt are bonds secured by irrevocable direct pay letters of credit or standby bond purchase agreements, and another $64 million are bonds directly placed with a financial institution. Debt supported by letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year, or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds are classified as current liabilities

The remaining $490 million of variable-rate debt includes $89 million of floating rate notes and $401 million of variable-rate bonds supported by the System's self-liquidity program. Debt supported by self-liquidity includes the Series 2014A CP Notes and certain variable-rate bonds that are remarketed in commercial paper or weekly mode. Debt supported by self-liquidity are classified as current liabilities. The System has sufficient liquidity within its investment portfolio to support the self-liquidity program. The System also maintains a $400 million revolving credit facility that can be drawn upon in the case of a failed remarketing of self-liquidity debt. The revolving credit facility expires in May 2022 and bears interest at a variable rate based on various interest rate benchmarks and spreads. There were no amounts outstanding under the revolving credit facility at March 31, 2020.

The System maintains the Cleveland Clinic Health System Obligated Group Commercial Paper Program (CP Program), which provides for the issuance of the Series 2014A CP Notes. The CP Program was established in November 2014 and will terminate no later than January 2044. The Series 2014A CP Notes may be issued from time to time in a maximum outstanding face amount of $100 million and are supported by the System's self-liquidity program. At March 31, 2020, the System did not have any outstanding Series 2014A CP Notes.

The System is subject to certain restricted covenants associated with its debt, including provisions related to certain debt ratios, days cash on hand, and other matters. The System was in compliance with these covenants at March 31, 2020.

In August 2018 the System through a UK subsidiary entered into a private placement agreement to issue the 2018 Sterling Notes totaling £665 million. The subsidiary received proceeds of £300 million, £100 million and £265 million in August 2018, November 2018 and August 2019, respectively. The outstanding 2018 Sterling Notes have been converted to U.S. dollars in the consolidated balance sheet using the respective exchange rate at March 31, 2020 and December 31, 2019.

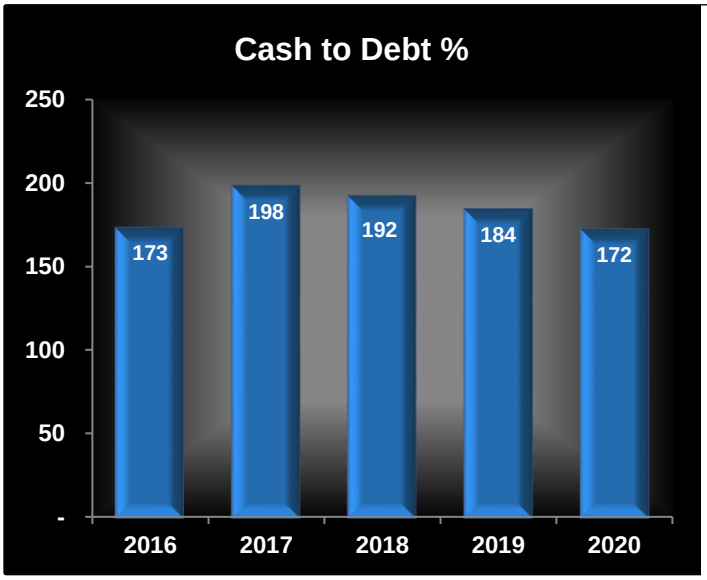
Outstanding long-term debt (including current portion) for the System as of March 31, 2020 and December 31, 2019 consist of the following:

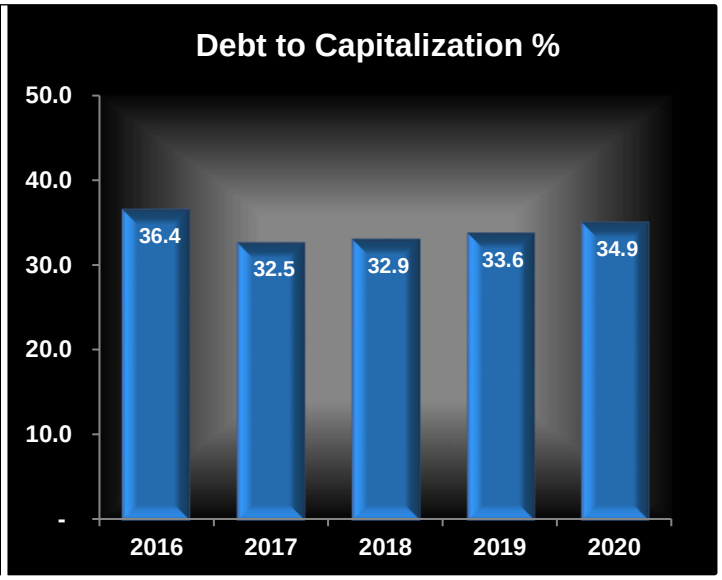
Hospital Revenue Bonds and Notes
(Dollars in thousands)

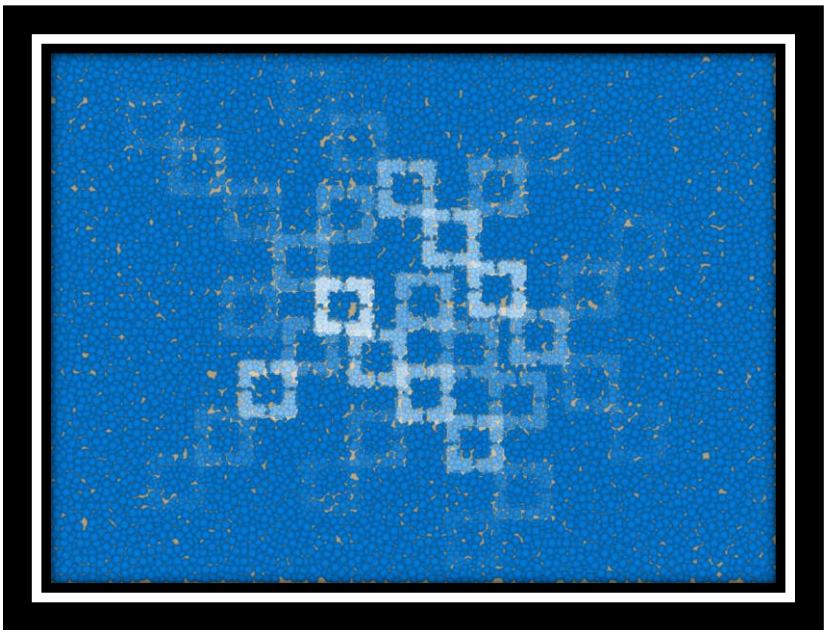
Series	Type	Final Maturity	March 31 2020	December 31 2019
2019A Revenue Bonds	Fixed	2046	$ 247,045	$ 247,045
2019B Revenue Bonds	Fixed	2046	250,320	250,320
2019C Revenue Bonds	Floating	2052	89,000	89,000
2019D Revenue Bonds	Variable	2052	119,340	119,340
2019E Revenue Bonds	Variable	2052	130,405	130,405
2019F Revenue Bonds	Variable	2052	130,405	130,405
2019G Revenue Bonds	Variable	2042	241,835	241,835
2018 Sterling Notes[1]	Fixed	2068	824,224	872,285
2018 Term Loan, Martin	Variable	2023	33,070	33,070
2017A Revenue Bonds	Fixed	2043	792,350	811,785
2017B Revenue Bonds	Fixed	2043	166,290	167,580
2017C Revenue Bonds	Fixed	2032	8,135	8,555
2016 Private Placement	Fixed	2046	325,000	325,000
2016 Term Loan	Variable	2026	15,170	15,170
2014 Taxable Bonds	Fixed	2114	400,000	400,000
2014A CP Notes	CP	2044	-	-
2013A Revenue Bonds	Fixed	2042	34,955	34,955
2013B Revenue Bonds	Variable	2039	201,160	201,160
2013 Keep Memory Alive Bonds	Variable	2037	56,980	56,980
2013 Bonds, Martin	Variable	2032	16,200	16,200
2012A Revenue Bonds	Fixed	2039	266,060	275,765
2011A Revenue Bonds	Fixed	2032	79,285	94,385
2011B Revenue Bonds	Fixed	2031	23,345	24,900
2011C Revenue Bonds	Fixed	2032	127,740	144,035
2010 Bonds, Martin	Fixed	2025	14,995	14,995
2008B Revenue Bonds	Variable	2043	327,575	327,575
2003C Revenue Bonds	Variable	2035	41,905	41,905
Notes Payable	Varies	Varies	3,435	3,584
Finance leases	Varies	Varies	115,979	118,053
			$ 5,082,203	$ 5,196,287

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

The following charts summarize cash-to-debt and debt-to-capitalization ratios for the System at December 31 for the last four years and at March 31, 2020:







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 2019, Moody's and S&P affirmed their respective ratings and outlooks. According to recent reports issued by Moody's and S&P, the ratings reflect a unique and strong enterprise profile, a strong leadership team and a national and international clinical reputation.

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

Bond Ratings

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

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

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

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended March 31, 2020 and 2019

Operating losses for the System in the first quarter of 2020 were $39.9 million, resulting in an operating margin of -1.5%, as compared to operating income of $36.2 million and an operating margin of 1.4% in the first quarter of 2019. The lower operating income resulted from a 5.6% increase in operating expenses driven by increases in salaries, wages and benefits and pharmaceutical expenses offset by a 2.5% increase in total unrestricted revenues. The increase in total unrestricted revenues was tempered by the suspension of non-essential procedures and appointments in mid-March due to the COVID-19 pandemic. Nonoperating losses for the System were $790.7 million in the first quarter of 2020 compared to nonoperating gains of $792.4 million in the first quarter of 2019. The decrease from the prior year was primarily due to unfavorable investment returns and the member substitution contribution for Martin Health System and Indian River Hospital that was recorded in the first quarter of 2019. Overall, the System reported a deficiency of revenues over expenses of $830.6 million in the first quarter of 2020 compared to an excess of revenues over expenses of $828.6 million in the first quarter of 2019.

The System's net patient service revenue increased $49.2 million (2.2%) in the first quarter of 2020 compared to the same period in 2019. Patients served in the first quarter of 2020 were lower than the same period in 2019 due to the impact of the COVID-19 pandemic. For a description of the impact and actions taken by the System see "CORONAVIRUS DISEASE (COVID-19)." Admissions increased by 1.4% in the first quarter 2020 compared to the same period in 2019, however, the System experienced a 6.7% decrease in total surgical cases and a 3.2% decrease in outpatient evaluation and management visits during the same period. Patients served in the first two months of 2020 were higher than the prior year, but the impact of suspending patient activity in mid-March created an unfavorable variance for the quarter. Net patient revenue has benefited from rate increases on the System's managed care contracts that became effective in 2020. The System has experienced an increase in Medicare and Medicaid revenue primarily as a result of demographic trends in the service area and other industry trends. On a combined basis, governmental and self-pay revenue as a percentage of total gross patient revenue has increased 0.4% in the first quarter of 2020 compared to the same period in 2019. The System has experienced a corresponding decrease in managed care and commercial gross revenues as a percentage of total gross patient revenues. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Other unrestricted revenues increased $13.2 million (5.5%) in the first quarter of 2020 compared to the same period in 2019. The increase in other unrestricted revenues was primarily due to a $10.5 million increase in outpatient pharmacy revenue, a $4.8 million increase in gifts and assets released from restriction and a $1.2 million increase in earnings from joint ventures recorded under the equity method of accounting. These increases were partially offset by a decrease of $1.0 million in management services revenue.

Total operating expenses increased $138.5 million (5.6%) in the first quarter of 2020 compared to the same period in 2019. Notable

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

Salaries, wages and benefits increased $76.8 million (5.4%) in the first quarter of 2020 compared to the same period in 2019. Salaries, excluding benefits, increased $62.4 million (5.2%) due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2019 and a 1.9% increase in average full-time equivalent employees in the first quarter of 2020 compared to the same period in 2019. Benefit costs increased $14.4 million (6.9%) during the same period. The System experienced a $5.4 million increase in defined contribution plan expenses, a $5.0 million increase in FICA expenses and a $3.0 million increase in employee healthcare costs.

Supplies expense increased $20.5 million (8.2%) in the first quarter of 2020 compared to the same period in 2019. The increase in supplies was comprised of a $16.6 million increase in implantables and other medical supplies. Lower surgical activity in the first quarter reduced certain medical supply costs, however the System incurred incremental supply costs for personal protective equipment and other supplies to scale up testing capacity of COVID-19, protect caregivers in the organization and provide safe and effective patient care at its facilities. Non-medical supplies increased by $3.9 million driven primarily by an increase in minor equipment and software and other supplies.

Pharmaceutical costs increased $28.2 million (9.4%) in the first quarter of 2020 compared to the same period in 2019. The increase in pharmaceutical costs is primarily due to higher costs and utilization of specialized drugs. The System operates a specialty pharmacy that is used to treat chronic illnesses and complex conditions. Specialty pharmacy expenses increased $10.3 million in the first quarter of 2020 compared to the same period in 2019. The System has also experienced a corresponding increase in outpatient pharmacy revenues related to specialty pharmaceuticals.

Purchased services and other fees increased $13.1 million (8.0%) in the first quarter of 2020 compared to the same period in 2019. The increase in purchased services and other fees was primarily related to a $4.8 million increase in state franchise fee expenses and a $2.0 million increase in software and hardware technology costs related to maintenance agreements and software subscriptions. The System also had other various costs related to certain System projects and initiatives.

Facilities expense decreased $4.8 million (5.0%) in the first quarter of 2020 compared to the same period in 2019. The decrease in facility expenses was primarily due to a $4.0 million decrease in rent and lease expenses and a $2.6 million decrease in utilities expense.

Insurance expense decreased by $2.6 million (10.1%) in the first quarter of 2020 compared to the same period in 2019. The decrease in insurance expense is primarily due to the

reduction in annual insurance premiums for Martin Health System that were based on a fiscal year. As the premiums expired in 2019, the insurance coverage was provided by the System's captive insurance subsidiary.

Interest expense increased $1.3 million (3.2%) in the first quarter of 2020 compared to the same period in 2019. The increase in interest expense is primarily due to the issuance of bonds in the second quarter of 2019 that added approximately $966 million of debt to the balance sheet and the issuance of the third tranche of the 2018 Sterling Notes in the third quarter of 2019 that added £265 million of debt to the balance sheet. These increases were offset by principal payments and the defeasance of approximately $249 million of debt previously incurred by Martin Health System.

Depreciation and amortization expenses increased $5.9 million (3.9%) in the first quarter of 2020 compared to the same period in 2019. Changes in depreciation include property, plant and equipment that was fully depreciated in 2018, offset by depreciation for property, plant and equipment that was acquired and placed into service after the first quarter of 2019.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net loss to the System of $790.7 million in the first quarter of 2020 compared to a net gains of $792.4 million in the first quarter of 2019, resulting in an unfavorable variance of $1,583 million. Investment returns were unfavorable by $1,094 million in the first quarter of 2020 compared to the same period in 2019. The System's long-term investment portfolio reported investment losses of approximately 8.7% for the first quarter of 2020 compared to gains of 4.8% in the first quarter of 2019. Derivative gains and losses were unfavorable by $69.0 million in the first quarter of 2020 compared to the same period in 2019. Derivative gains and losses result from changes in currency exchange rates associated with the System's foreign exchange forward currency contracts and changes in interest rate benchmarks associated with the System's interest rate swap agreements, including net interest paid or received under the swap agreements. Other nonoperating gains and losses were unfavorable by $419.9 million in the first quarter of 2020 compared to the same period in 2019 primarily due to a $428.4 million member substitution contribution in 2019 related to the acquisitions of Martin Health System and Indian River Hospital.

BALANCE SHEET – MARCH 31, 2020 COMPARED TO DECEMBER 31, 2019

Cash and cash equivalents increased $84.4 million (16.7%) from December 31, 2019 to March 31, 2020. The majority of the System's cash and cash equivalents are held in operating bank accounts for general expenditures. The increase relates to the timing of operating cash flows and transfers to or from the investment portfolio.

Patient accounts receivable decreased $24.6 million (1.9%) from December 31, 2019 to March 31, 2020. The decrease in patient receivables is primarily attributable to the decrease in patients served at the end of the first quarter of 2020 due to the impact of the COVID-19 pandemic. The System has various initiatives to enhance cash collection efforts and create efficiencies in the revenue cycle process. Days revenue outstanding for the System increased from 49 days at December 31, 2019 to 50 days at March 31, 2020.

Investments for current use decreased $119.4 million (66.8%) from December 31, 2019 to March 31, 2020. Investments for current use includes funds held by the bond trustee that are used to pay current debt service payments. The System paid $119.4 million to the bond trustee in 2019 to fund debt service payments that occurred in the first quarter of 2020. There were no funds held by the bond trustee reported in investments for current use as of March 31, 2020. Investments for current use also includes assets held for self-insurance that will be used to pay the current portion of estimated claim liabilities. There were no changes in these investments from December 31, 2019 to March 31, 2020.

Other current assets increased $39.0 million (8.0%) from December 31, 2019 to March 31, 2020. The increase in other current assets was primarily due to a $20.2 million increase in prepaid expenses driven by annual information technology contracts and a $21.2 million increase in management fee receivables.

Unrestricted long-term investments decreased by $905.8 million (9.8%) from December 31, 2019 to March 31, 2020. The decrease in long-term investments was primarily due to $723 million of unrestricted investment losses experienced in the System's investment portfolio that experienced losses of 8.7% in first quarter of 2020.

Funds held by trustees increased $39.9 million (17.7%) from December 31, 2019 to March 31, 2020. The increase in funds held by trustees is primarily due to a $37.5 million increase in collateral posted with the counterparties on the System's derivative contracts.

Assets held for self-insurance decreased by $38.5 million (24.4%) from December 31, 2019 to March 31, 2020. The decrease in self-insurance assets is primarily due to the payment of a $28.0 million dividend from the System's captive insurance subsidiary to the Clinic and negative investment returns in the System's captive insurance investment portfolio experienced in the first quarter of 2020.

Donor restricted assets decreased $40.8 million (4.7%) from December 31, 2019 to March 31, 2020. The decrease in donor restricted assets was primarily from investment losses on restricted investments and the expenditures from restricted funds in excess of the receipt of donor restricted gifts.

Net property, plant and equipment decreased $31.1 million (0.5%) from December 31, 2019 to March 31, 2020. The System had net expenditures for property, plant and equipment of $174.7 million, offset by depreciation expense of $155.0 million. The System also had proceeds from the sale of property, plant and equipment of $1.9 million and foreign currency translation losses of $29.0 million. Capital expenditures in 2020 include amounts paid on retainage liabilities recorded at December 31, 2019 and exclude assets acquired through finance leases and other financing arrangements. Retainage liabilities decreased $24.6 million, and new finance leases totaled $4.6 million. Expenditures for property, plant and equipment were incurred at numerous facilities across the System and include expenditures for strategic construction, expansion and technological investment as well as replacement of existing facilities and equipment. For a description of a few of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Operating lease right-of-use assets decreased $11.0 million (3.4%) from December 31, 2019 to March 31, 2020. The decrease in operating lease right-of-use assets was due to the reduction of the value of future lease payments through the recognition of operating lease expenses of $11.6 million partially offset by the addition of new

operating leases recorded during the period of $8.2 million.

Other noncurrent assets decreased $7.5 million (1.4%) from December 31, 2019 to March 31, 2020. The decrease other noncurrent assets was primarily due to a $9.2 million decrease in deferred compensation plan assets.

Accounts payable decreased $78.4 million (14.6%) from December 31, 2019 to March 31, 2020. The decrease in accounts payable was primarily attributable to the timing of payment processing for trade payables, a $24.6 million decrease in retainage liabilities for current construction projects and a $22.9 million decrease in outstanding checks.

Compensation and amounts withheld from payroll increased $57.3 million (13.3%) from December 31, 2019 to March 31, 2020. The change was primarily attributable to the timing of payroll and the growth in employee benefit accruals.

Current portion of long-term debt increased $3.8 million (4.0%) from December 31, 2019 to March 31, 2020. Changes in the current portion of long-term debt include the reclassification of regularly scheduled principal payments from long-term to current that are due within one year, offset by principal payments made in 2020.

Variable rate debt classified as current was unchanged from December 31, 2019 to March 31, 2020. Long-term debt classified as current consists of variable-rate bonds supported by the System's self-liquidity program and bonds with letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year or contain a subjective clause that would allow the lender to declare an event of default and cause immediate repayment of such bonds.

Other current liabilities decreased $46.9 million (8.2%) from December 31, 2019 to March 31, 2020. Decreases in other current liabilities include a $33.4 million decrease in accrued interest payable related to debt that pays interest semi-annually in January and July of each year and a $26.9 million decrease in state franchise fee liabilities primarily related to the timing of payments to the State of Ohio. These decreases were offset by a $17.3 million increase in derivative liabilities related to foreign currency contracts.

Long-term debt decreased $119.0 million (2.5%) from December 31, 2019 to March 31, 2020. The decrease in long-term debt is primarily due to the reclassification of regularly scheduled principal payments from long-term to current for debt payments due within one year and foreign currency translation gains on the 2018 Sterling Notes.

Professional and general insurance liability reserves increased $12.2 million (7.4%) from December 31, 2019 to March 31, 2020. The increase in insurance liability reserves is due to expenses recorded for the accrual of current year claims estimates in excess of claim liability payments.

Accrued retirement benefits decreased $30.3 million (8.7%) from December 31, 2019 to March 31, 2020. The decrease in accrued retirement benefits is comprised of a $29.7 million decrease in the System's defined benefit pension plan liabilities and a $0.6 million decrease in other postretirement benefit liabilities. In the first quarter of 2020, the System funded $16.4 million to the Indian River Retirement Plan. The decrease in defined benefit pension plan liabilities was also due to net periodic benefit, which resulted from the expected return on plan assets in excess of interest cost incurred on plan obligations.

Operating lease liabilities decreased $9.8 million (3.3%) from December 31, 2019 to March 31, 2020. The decrease in operating lease liabilities was due to operating lease payments partially offset by the addition of new operating leases recorded during the period of $8.2 million.

Other noncurrent liabilities increased $56.7 million (10.5%) from December 31, 2019 to March 31, 2020. The increase in other noncurrent liabilities is primarily due a $55.8 million increase in liabilities related to the System's derivative agreements and $10.7 million of noncurrent social security payroll tax liabilities that have been deferred under the provisions of the CARES act. These increases were partially offset by a $10.2 million decrease in deferred compensation plan liabilities.

Total net assets decreased $867.0 million (7.4%) from December 31, 2019 to March 31, 2020. Net assets without donor restrictions decreased $823.2 million (7.8%) primarily due to a deficiency of revenues over expenses of $830.6 million offset by net assets released from restriction for capital purposes of $3.1 million. Net assets with donor restrictions decreased $43.8 million (3.6%), primarily due to investment losses of $56.7 million and $15.6 million of assets released from restrictions offset by donor restricted gifts of $29.2 million.

Cleveland Clinic Sydell & Arnold Miller Family Pavilion
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:

- The impact of a pandemic, epidemic or outbreak of an infectious disease such as the novel coronavirus disease (COVID-19), including but not limited to (1) a quarantine, temporary shutdown, overburdening of facilities or diversion of patients, (2) bed, staffing or supply shortages, (3) reduced patient volumes and operating revenues, or (4) the loss of employment and health insurance for a significant portion of the population;
- Changes to the Medicare and Medicaid reimbursement systems resulting in reductions in payments and/or changes in eligibility of patients to qualify for Medicare and Medicaid;
- Legislative reforms or actions that reduce the payment for, and/or utilization of, healthcare services, such as the Patient Protection and Affordable Care Act and/or draft legislation to address reimbursement cuts related to the Sustainable Growth Rate Formulas;
- Possible repeal and/or replacement of the Patient Protection and Affordable Care Act, and repeal of the individual mandate;
- Adjustments resulting from Medicare and Medicaid reimbursement audits, including audits initiated by the Medicare Recovery Audit Contractor program;
- Future contract negotiations between public and private insurers, employers and participating hospitals, including the System's hospitals, and other efforts by these insurers and employers to limit hospitalization costs and coverage;
- Increased competition in the areas served by the System and limited options to respond to the same in part due to uncertainty in the enforcement of antitrust laws;
- The ability of the System to integrate the hospitals in Florida into a regional health system;
- The ability of the System to access capital for the funding of capital projects;
- Availability of malpractice insurance at reasonable rates, if at all;
- The System's ability to recruit and retain professionals;
- The ability of the Clinic to develop the London Hospital and establish relationships with payors in that market;
- General economic and business conditions, internationally, nationally and regionally, including the impact of interest rates, foreign currencies, financial market conditions and volatility and increases in the number of self-pay patients;
- The increasing number and severity of cyber threats and the costs of preventing them and protecting patient and other data;
- The declining population in the Greater Cleveland area;
- Impact of federal and state laws on tax-exempt organizations relating to exemption from income taxes, sales taxes, real estate taxes, excise taxes and bond financing, including the Tax Cuts and Jobs Act;
- Management, utilization and increases in the cost of medical drugs and devices as technological advancement progresses without concurrent increases in federal reimbursement;
- Ability of the System to adjust its cost structure and reduce operating expenses; and
- Changes in accounting standards or practices.

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