Interim Unaudited Consolidated Financial Statements and Other Information

For The Period Ended June 30, 2014

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

Contents

Unaudited Consolidated Balance Sheets

($ in thousands)

	June 30 2014	December 31 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 83,661	$ 70,900
Patient receivables, net	857,381	779,676
Investments for current use	47,306	139,129
Other current assets	275,445	295,059
Total current assets	1,263,793	1,284,764
Investments:		
Long-term investments	5,335,018	5,057,251
Funds held by trustees	94,352	70,627
Assets held by captive insurance subsidiary	110,202	95,666
Donor restricted assets	448,488	428,722
	5,988,060	5,652,266
Property, plant, and equipment, net	3,521,364	3,539,781
Other assets:		
Pledges receivable, net	149,682	135,457
Trusts and interests in foundations	122,194	118,274
Other noncurrent assets	230,537	221,257
	502,413	474,988
Total assets	$ 11,275,630	$ 10,951,799

Unaudited Consolidated Balance Sheets (continued)

($ in thousands)

	June 30 2014	December 31 2013
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 270,022	$ 325,014
Compensation and amounts withheld from payroll	294,394	256,149
Current portion of long-term debt	53,895	52,498
Variable rate debt classified as current	488,090	488,230
Other current liabilities	355,598	381,549
Total current liabilities	1,461,999	1,503,440
Long-term debt:		
Hospital revenue bonds	2,300,079	2,343,380
Notes payable and capital leases	84,948	86,626
	2,385,027	2,430,006
Other liabilities:		
Professional and general insurance liability reserves	145,551	133,176
Accrued retirement benefits	252,004	263,259
Other noncurrent liabilities	439,252	413,512
	836,807	809,947
Total liabilities	4,683,833	4,743,393
Net assets:		
Unrestricted	5,813,241	5,478,927
Temporarily restricted	503,004	461,110
Permanently restricted	275,552	268,369
Total net assets	6,591,797	6,208,406
Total liabilities and net assets	$ 11,275,630	$ 10,951,799

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Three Months ended June 30 2014	2013 *As Adjusted (See Note 4)*
Unrestricted revenues		
Net patient service revenue	$1,591,463	$1,587,235
Provision for uncollectible accounts	(103,496)	(108,652)
Net patient service revenue less provision for uncollectible accounts	1,487,967	1,478,583
Other	155,719	156,846
Total unrestricted revenues	1,643,686	1,635,429
Expenses		
Salaries, wages, and benefits	920,220	907,728
Supplies	153,954	163,840
Pharmaceuticals	141,216	120,862
Purchased services and other fees	89,529	100,615
Administrative services	42,915	40,229
Facilities	75,116	75,277
Insurance	18,949	15,292
	1,441,899	1,423,843
Operating income before interest, depreciation, and amortization expenses	201,787	211,586
Interest	26,097	26,789
Depreciation and amortization	96,807	94,749
Operating income	78,883	90,048
Nonoperating gains and losses		
Investment gain (loss)	176,185	(13,803)
Derivative (losses) gains	(19,761)	34,096
Other, net	128	106
Net nonoperating gains and losses	156,552	20,399
Excess of revenues over expenses	235,435	110,447

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Total net assets at April 1, 2013	$ 4,585,856	$ 435,726	$ 255,643	$ 5,277,225
Excess of revenues over expenses, *as adjusted (see Note 4)*	110,447	-	-	110,447
Donated capital and assets released from restrictions for capital purposes	3,360	(3,114)	-	246
Gifts and bequests	-	8,482	866	9,348
Transfer of net assets	647	(647)	-	-
Net investment income	-	934	-	934
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(6,606)	-	(6,606)
Retirement benefits adjustment, *as adjusted (see Note 4)*	(2,273)	-	-	(2,273)
Change in interests in foundations	-	(612)	875	263
Change in value of perpetual trusts	-	-	605	605
Net change in unrealized losses on nontrading investments	(432)	-	-	(432)
Other	1,952	-	-	1,952
Increase (decrease) in net assets	113,701	(1,563)	2,346	114,484
Total net assets at June 30, 2013	$ 4,699,557	$ 434,163	$ 257,989	$ 5,391,709
Total net assets at April 1, 2014	$ 5,584,273	$ 480,071	$ 270,796	$ 6,335,140
Excess of revenues over expenses	235,435	-	-	235,435
Donated capital and assets released from restrictions for capital purposes	1,494	(1,492)	-	2
Gifts and bequests	-	22,820	4,028	26,848
Net investment income	-	9,328	-	9,328
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(8,220)	-	(8,220)
Retirement benefits adjustment	(765)	-	-	(765)
Change in interests in foundations	-	497	-	497
Change in value of perpetual trusts	-	-	728	728
Net change in unrealized losses on nontrading investments	(7,152)	-	-	(7,152)
Other	(44)	-	-	(44)
Increase in net assets	228,968	22,933	4,756	256,657
Total net assets at June 30, 2014	$ 5,813,241	$ 503,004	$ 275,552	$ 6,591,797

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Six Months Ended June 30	
	2014	2013
		As Adjusted (See Note 4)
Unrestricted revenues		
Net patient service revenue	$ 3,152,589	$ 3,150,626
Provision for uncollectible accounts	(209,338)	(213,905)
Net patient service revenue less provision for uncollectible accounts	2,943,251	2,936,721
Other	285,331	294,446
Total unrestricted revenues	3,228,582	3,231,167
Expenses		
Salaries, wages, and benefits	1,849,942	1,814,092
Supplies	301,749	321,604
Pharmaceuticals	267,899	236,933
Purchased services and other fees	179,153	188,958
Administrative services	80,481	76,109
Facilities	147,759	148,859
Insurance	35,087	30,859
	2,862,070	2,817,414
Operating income before interest, depreciation, and amortization expenses	366,512	413,753
Interest	52,402	53,607
Depreciation and amortization	193,397	191,521
Operating income	120,713	168,625
Nonoperating gains and losses		
Investment return	244,544	150,003
Derivative (losses) gains	(42,960)	45,699
Other, net	(30)	(26)
Net nonoperating gains and losses	201,554	195,676
Excess of revenues over expenses	322,267	364,301

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

($ in thousands)

Changes in Net Assets

	Net Assets			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at January 1, 2013	$ 4,332,388	$ 425,234	$ 244,758	$ 5,002,380
Excess of revenues over expenses, *as adjusted (see Note 4)*	364,301	-	-	364,301
Donated capital and assets released from restrictions for capital purposes	4,008	(3,596)	-	412
Gifts and bequests	-	24,217	11,249	35,466
Transfer of net assets	992	(992)	-	-
Net investment income	-	9,350	-	9,350
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(19,438)	-	(19,438)
Retirement benefits adjustment *as adjusted (see Note 4)*	(4,546)	-	-	(4,546)
Change in interests in foundations	-	(612)	875	263
Change in value of perpetual trusts	-	-	1,107	1,107
Net change in unrealized gains on nontrading investments	387	-	-	387
Other	2,027	-	-	2,027
Increase in net assets	367,169	8,929	13,231	389,329
Balances at June 30, 2013	$ 4,699,557	$ 434,163	$ 257,989	$ 5,391,709
Balances at January 1, 2014	$ 5,478,927	$ 461,110	$ 268,369	$ 6,208,406
Excess of revenues over expenses	322,267	-	-	322,267
Donated capital and assets released from restrictions for capital purposes	3,008	(3,006)	-	2
Gifts and bequests	-	46,767	5,763	52,530
Transfer of net assets	92	(92)	-	-
Net investment income	-	12,632	-	12,632
Net assets released from restrictions used for operations included in other unrestricted revenues	-	(15,084)	-	(15,084)
Retirement benefits adjustment	(1,529)	-	-	(1,529)
Change in interests in foundations	-	677	-	677
Change in value of perpetual trusts	-	-	1,420	1,420
Net change in unrealized gains on nontrading investments	10,658	-	-	10,658
Other	(182)	-	-	(182)
Increase in net assets	334,314	41,894	7,183	383,391
Balances at June 30, 2014	$ 5,813,241	$ 503,004	$ 275,552	$ 6,591,797

See notes to unaudited consolidated financial statements.

Unaudited Consolidated Statements of Cash Flows

($ in thousands)

	Six Months Ended June 30 2014	2013 *As Adjusted (See Note 4)*
Operating activities and net nonoperating gains and losses		
Increase in net assets	$ 383,391	$ 389,329
Adjustments to reconcile increase in net assets to net cash provided by operating activities and net nonoperating gains and losses:		
Loss on extinguishment of debt	-	(383)
Retirement benefits adjustment	1,529	4,546
Net realized and unrealized gains on investments	(248,553)	(139,790)
Depreciation and amortization	193,397	191,521
Provision for uncollectible accounts	209,338	213,905
Donated capital	(2)	(412)
Restricted gifts, bequests, investment income, and other	(67,259)	(46,186)
Accreted interest and amortization of bond premiums	(1,266)	(1,355)
Net loss (gain) in value of derivatives	30,081	(58,723)
Changes in operating assets and liabilities:		
Patient receivables	(287,043)	(287,690)
Other current assets	29,306	54,111
Other noncurrent assets	(9,857)	(1,337)
Accounts payable and other current liabilities	(34,695)	(47,283)
Other liabilities	(4,750)	(31,026)
Net cash provided by operating activities and net nonoperating gains and losses	193,617	239,227
Financing activities		
Proceeds from long-term borrowings	-	309,435
Payments for advance refunding of long-term debt	-	(287,306)
Principal payments on long-term debt	(48,995)	(49,758)
Debt issuance costs	-	(2,129)
Change in pledges receivables, trusts and interests in foundations	(27,837)	9,607
Restricted gifts, bequests, investment income, and other	67,259	46,186
Net cash (used in) provided by financing activities	(9,573)	26,035
Investing activities		
Expenditures for property and equipment, net	(175,865)	(145,303)
Net change in cash equivalents reported in long-term investments	(91,821)	75,325
Purchases of investments	(751,752)	(945,636)
Sales of investments	848,155	799,241
Net cash used in investing activities	(171,283)	(216,373)
Increase in cash and cash equivalents	12,761	48,889
Cash and cash equivalents at beginning of year	70,900	82,793
Cash and cash equivalents at end of period	$ 83,661	$ 131,682

See notes to unaudited consolidated financial statements.

1. Basis of Presentation

The accompanying unaudited consolidated financial statements have been prepared in accordance with generally accepted accounting principles (GAAP) for interim financial information. Accordingly, they do not include all of the information and footnotes required by GAAP for complete financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation have been included and are of a normal and recurring nature. Operating results for the three and six months ended June 30, 2014 are not necessarily indicative of the results to be expected for the year ending December 31, 2014. For further information, refer to the audited financial statements and notes thereto for the year ended December 31, 2013.

2. Organization and Consolidation

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

The System is the leading provider of healthcare services in northeast Ohio. The System operates eleven hospitals with approximately 3,600 staffed beds. Ten of the hospitals are located in the Cleveland metropolitan area, anchored by the Foundation. The System operates eighteen outpatient family health centers, ten ambulatory surgery centers, as well as a large number of physician offices, which are located throughout a seven-county area of northeast Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada, a specialized neurological clinical center in Las Vegas, Nevada, and specialized cancer centers in Sandusky and Mansfield, Ohio. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio with approximately 180 staffed beds, and in cooperation with Abu Dhabi Health Services Company, the Sheikh Khalifa Medical City (SKMC), a network of healthcare facilities in Abu Dhabi, United Arab Emirates with approximately 760 staffed beds.

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

3. 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.

4. Change in Accounting Principle

In 2013, the System changed the method for recognizing actuarial gains and losses associated with pension and other postretirement benefit plans. The new method recognizes actuarial gains and losses in excess of the corridor, which is 10% of the greater of the projected benefit obligation or the fair value of plan assets, as a component of net periodic benefit cost in the current period. Previously, actuarial gains and losses that exceeded the corridor were amortized as a component of net periodic benefit cost over the average expected remaining service of active participants. The new method is preferable because it recognizes actuarial gains and losses in the year incurred rather than amortizing the gains and losses over future years.

In addition, in 2013 the System changed the method for determining the market-related value of assets, the asset measurement used to determine certain components of net periodic benefit cost, for the System's pension plans. Previously, asset gains and losses (realized and unrealized) were deferred over a five-year period. The new method immediately recognizes all asset gains and losses. Consistent with the change above, the new method is preferable because it recognizes actuarial gains and losses in the year incurred rather than deferring recognition to future years.

The adoption of the new methods has been applied retrospectively, and therefore, actuarial gains and losses have been updated for the voluntary changes in accounting principles. The impact of the changes resulted in a $8.8 million and $17.7 million increase in excess of revenues over expenses and a corresponding decrease in retirement benefits adjustment in the consolidated statement of operations and changes in net assets for the three months ended June 30, 2013 and the six months ended June 30, 2013, respectively. The accounting changes had no impact on the total amount of previously reported net assets.

4. Change in Accounting Principle (continued)

The following table presents the impact of the retrospective changes in accounting principles for pension and other postretirement benefit plans on the consolidated statements of operations and changes in net assets and consolidated statements of cash flows (in thousands):

	Three Months Ended June 30, 2013		
	Previous Accounting Method	Impact of Accounting Change	As Adjusted
Consolidated Statement of Operations and Changes in Net Assets			
Operations:			
Salaries, wages and benefits	$ 916,571	$ (8,843)	$ 907,728
Excess of revenues over expenses	101,604	8,843	110,447
Changes in net assets:			
Retirement benefits adjustment	6,570	(8,843)	(2,273)

	Six Months Ended June 30, 2013		
	Previous Accounting Method	Impact of Accounting Change	As Adjusted
Consolidated Statement of Operations and Changes in Net Assets			
Operations:			
Salaries, wages and benefits	$ 1,831,778	$ (17,686)	$ 1,814,092
Excess of revenues over expenses	346,615	17,686	364,301
Changes in net assets:			
Retirement benefits adjustment	13,140	(17,686)	(4,546)
Consolidated Statement of Cash Flows			
Operating activities:			
Retirement benefits adjustment	$ (13,140)	$ 17,686	$ 4,456
Decrease in other liabilities	(13,340)	(17,686)	(31,026)

5. Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation, which had no impact on previously reported excess of revenues over expenses or net assets.

6. Net Patient Service Revenue and Patient Receivables

Net patient service revenue before the provision for uncollectible accounts by major payor source for the six months ended June 30, 2014 and 2013, are as follows (in thousands):

	2014		**2013**	
Medicare	**$ 908,534**	**29%**	$ 923,126	29%
Medicaid	**170,873**	**6**	145,615	5
Managed care and commercial	**1,936,469**	**61**	1,897,794	60
Self-pay	**136,713**	**4**	184,091	6
	$ 3,152,589	**100%**	$ 3,150,626	100%

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

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

For patient receivables associated with self-pay patients, including patients with deductible and copayment balances for which third-party coverage provides for a portion of the services provided, the System records an estimated provision for uncollectible accounts in the year of service. As a result of the Affordable Care Act, former uninsured patients are shifting into the expanded Ohio Medicaid program and the newly formed Health Insurance Exchanges. Self-pay write-offs decreased $18.5 million in the first six months of 2014 compared to the same period in 2013. The System does not maintain a material allowance for uncollectible accounts from third-party payors.

7. Fair Value Measurement

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.

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

The fair value of the System's pledges receivable is based on discounted cash flow analysis using Treasury yield curve interest rates consistent with the maturities of the pledges receivable and adjusted for consideration of the donor's credit. The fair value of the pledges receivable was $205.8 million and $179.3 million at June 30, 2014 and December 31, 2013, respectively. The carrying value of the System's pledges receivable was $204.3 million and $180.4 million at June 30, 2014 and December 31, 2013, respectively. Pledges receivable would be classified as level 3 in the fair value hierarchy.

7. Fair Value Measurement (continued)

The fair value of the System's long-term debt is estimated by discounted cash flow analyses using current borrowing rates for similar types of borrowing arrangements and adjusted for the System's credit. Inputs, which include reported/comparable trades, broker/dealer quotes, bids and offerings, are obtained from various sources, including market participants, dealers, brokers and various news media/market information. The fair value of long-term debt was $3.0 billion at June 30, 2014 and $2.9 billion at December 31, 2013, respectively. The carrying value of the System's long-term debt was $2.8 billion at June 30, 2014 and $2.9 billion at December 31, 2013. Long-term debt would be classified as level 2 in the fair value hierarchy.

The following tables present the financial instruments measured at fair value on a recurring basis as of June 30, 2014 and December 31, 2013, based on the valuation hierarchy (in thousands):

	June 30, 2014			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	357,606	15	–	357,621
Fixed income securities:				
U.S. treasuries	642,165	–	–	642,165
U.S. government agencies	–	23,913	–	23,913
U.S. corporate	–	165,106	–	165,106
U.S. government agencies asset-backed	–	6,259	–	6,259
Corporate asset-backed	–	12,744	–	12,744
Foreign	–	45,379	–	45,379
Fixed income mutual fund	15,159	–	–	15,159
Commingled fixed income funds	–	795,983	–	795,983
Common and preferred stocks				
U.S.	597,270	2,581	–	599,851
Foreign	438,948	1,584	–	440,532
Commingled equity funds	–	1,102,403	–	1,102,403
Total cash and investments	2,051,148	2,155,967	–	4,207,115
Perpetual and charitable trusts	–	65,116	–	65,116
Total assets at fair value	$ 2,051,148	$ 2,221,083	$ –	$ 4,272,231
Liabilities				
Interest rate swaps	$ –	$ 128,483	$ –	$ 128,483

7. Fair Value Measurement (continued)

	December 31, 2013			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and investments:				
Cash and cash equivalents	252,398	643	–	253,041
Fixed income securities:				
U.S. treasuries	622,899	–	–	622,899
U.S. government agencies	–	23,563	–	23,563
U.S. corporate	–	174,152	–	174,152
U.S. government agencies asset-backed	–	7,449	–	7,449
Corporate asset-backed	–	6,924	–	6,924
Foreign	–	30,247	–	30,247
Fixed income mutual fund	15,052	–	–	15,052
Commingled fixed income funds	–	758,376	–	758,376
Common and preferred stocks:				
U.S.	620,931	948	–	621,879
Foreign	477,848	-	–	477,848
Commingled equity funds	–	955,515	–	955,515
Total cash and investments	1,989,128	1,957,817	–	3,946,945
Perpetual and charitable trusts	–	61,874	–	61,874
Total assets at fair value	$ 1,989,128	$ 2,019,691	$ –	$ 4,008,819
Liabilities				
Interest rate swaps	$ –	$ 98,402	$ –	$ 98,402

7. Fair Value Measurement (continued)

Financial instruments at June 30, 2014 and December 31, 2013 are reflected in the consolidated balance sheets as follows (in thousands):

	June 30 2014	December 31 2013
Cash, cash equivalents, and investments measured at fair value	$ 4,207,115	$ 3,946,945
Alternative investments accounted for under the equity method	1,911,912	1,915,350
Total cash, cash equivalents, and investments	$ 6,119,027	$ 5,862,295
Perpetual and charitable trusts measured at fair value	$ 65,116	$ 61,874
Interests in foundations	57,078	56,400
Trusts and interests in foundations	$ 122,194	$ 118,274

Interest rate swaps (Note 8) are reported in other noncurrent liabilities in the consolidated balance sheets.

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

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

The fair value of perpetual and charitable trusts in which the System receives periodic payments from the trust is determined based on the present value of expected cash flows to be received from the trust using discount rates ranging from 3.8% to 5.0%, which are based on Treasury yield curve 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 Measurement (continued)

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

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

8. Interest Rate Swaps

The System's objective with respect to interest rate risk is to manage the risk of rising interest rates on the System's variable-rate debt and certain variable-rate operating lease payments. Consistent with its interest rate risk management objective, the System entered into various interest rate swap agreements with a total outstanding notional amount of $614.5 million and $625.4 million at June 30, 2014 and December 31, 2013, 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) gains on the consolidated statements of operations and changes in net assets.

8. Interest Rate Swaps (continued)

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

Swap Type	Expiration Date	System Pays	System Receives	Notional Amount at June 30 2014	Notional Amount at December 31 2013
Fixed	2016	5.28%	100% of SIFMA	8,080	11,810
Fixed	2021	3.21%	68% of LIBOR	36,240	37,670
Fixed	2024	3.42%	68% of LIBOR	28,800	29,300
Fixed	2027	3.56%	68% of LIBOR	135,939	139,525
Fixed	2028	5.12%	100% of LIBOR	40,785	41,710
Fixed	2028	3.51%	68% of LIBOR	31,495	32,085
Fixed	2030	5.07%	100% of LIBOR	62,500	62,500
Fixed	2030	5.06%	100% of LIBOR	62,500	62,500
Fixed	2032	4.32%	79% of LIBOR	2,541	2,574
Fixed	2032	4.33%	70% of LIBOR	5,083	5,147
Fixed	2032	3.78%	70% of LIBOR	2,541	2,574
Fixed	2036	4.90%	100% of LIBOR	50,000	50,000
Fixed	2036	4.90%	100% of LIBOR	79,375	79,375
Fixed	2037	4.62%	100% of SIFMA	68,600	68,600
				$ 614,479	$ 625,370

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

	Liability Derivatives			
	June 30, 2014		December 31, 2013	
Derivatives not designated as hedging instruments	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Interest rate swap agreements	Other noncurrent liabilities	$128,483	Other noncurrent liabilities	$98,402

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

Derivatives not designated as hedging instruments	Location of (Loss) Gain Recognized	Quarter ended June 30 2014	Quarter ended June 30 2013	Six months ended June 30 2014	Six months ended June 30 2013
Interest rate swap agreements	Derivative (losses) gains	($19,761)	$34,096	($42,960)	$45,699

8. Interest Rate Swaps (continued)

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 reached certain thresholds established in the derivative contracts, the System is required to post collateral, which could adversely affect its liquidity. At June 30, 2014 and December 31, 2013, the System posted $63.7 million and $41.9 million, respectively, of collateral that is included in funds held by trustee 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 has two defined benefit pension plans, including the CCHS Retirement Plan, which covers substantially all of the System's employees. The benefits provided are based on age, years of service and compensation. The System's policy is to fund at least the minimum amounts required by the Employee Retirement Income Security Act. The CCHS Retirement Plan ceased benefit accruals as of December 31, 2009 for substantially all employees. Benefit accruals ceased for remaining employees at various intervals through December 31, 2012. The System also maintains a nonqualified defined benefit supplemental retirement plan, which covers certain of its employees.

The System sponsors two noncontributory, defined contribution plans and a contributory, defined contribution plan. The Cleveland Clinic Investment Pension Plan (IPP) is a noncontributory, defined contribution plan, which covers substantially all of the System's employees. The System's contribution for the IPP is based upon a percentage of employee compensation and years of service. The System sponsors an additional noncontributory, defined contribution plan, which covers certain of its employees. The System's contribution to the plan is based upon a percentage of employee compensation, as defined, determined according to age. The System also sponsors a contributory, defined contribution plan, which covers substantially all employees. The System's contribution to the contributory plan is determined based on employee contributions.

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

	Quarter Ended June 30		Six Months Ended June 30	
	2014	**2013**	**2014**	**2013**
Amounts related to defined benefit pension plans:				
Service cost	$ 581	$ 365	$ 1,162	$ 729
Interest cost	17,968	16,430	35,935	32,860
Expected return on assets	(25,180)	(22,144)	(50,360)	(44,289)
Net amortization and deferral	(165)	(164)	(330)	(328)
Total defined benefit pension plans	(6,796)	(5,513)	(13,593)	(11,028)
Defined contribution plans	50,349	47,143	101,890	97,128
	$ 43,553	$ 41,630	$ 88,297	$ 86,100

9. Pensions and Other Postretirement Benefits (continued)

As of June 30, 2014, the System has made contributions of $2.7 million to the defined benefit pension plans. The System expects to make additional contributions of $2.7 million to the defined benefit pension plans for the remainder of 2014.

10. Subsequent Events

The System evaluated events and transactions occurring subsequent to June 30, 2014 through August 15, 2014, the date the financial statements were issued. During this period, there were no subsequent events requiring recognition in the consolidated financial statements, and there were no nonrecognized subsequent events requiring disclosure.

Unaudited Consolidating Balance Sheets

($ in thousands)

	June 30, 2014				December 31, 2013			
	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	$ 34,211	$ 49,450	$ -	$ 83,661	$ -	$ 70,900	$ -	$ 70,900
Patient receivables, net	840,189	36,770	(19,578)	857,381	767,742	32,725	(20,791)	779,676
Due from affiliates	15,288	38,096	(53,384)	-	2,387	3	(2,390)	-
Investments for current use	-	47,306	-	47,306	91,823	47,306	-	139,129
Other current assets	248,118	31,433	(4,106)	275,445	270,502	25,745	(1,188)	295,059
Total current assets	1,137,806	203,055	(77,068)	1,263,793	1,132,454	176,679	(24,369)	1,284,764
Investments:								
Long-term investments	5,124,565	210,453	-	5,335,018	4,849,078	208,173	-	5,057,251
Funds held by trustees	94,352	-	-	94,352	70,627	0	-	70,627
Assets held by captive insurance subsidiary	-	110,202	-	110,202	-	95,666	-	95,666
Donor restricted assets	436,371	12,117	-	448,488	416,634	12,088	-	428,722
	5,655,288	332,772	-	5,988,060	5,336,339	315,927	-	5,652,266
Property, plant, and equipment, net	3,245,581	275,783	-	3,521,364	3,262,478	277,303	-	3,539,781
Other assets:								
Pledges receivable, net	144,908	4,774	-	149,682	131,118	4,339	-	135,457
Trusts and beneficial interests in foundations	82,395	39,799	-	122,194	78,806	39,468	-	118,274
Other noncurrent assets	238,529	3,678	(11,670)	230,537	227,219	3,412	(9,374)	221,257
	465,832	48,251	(11,670)	502,413	437,143	47,219	(9,374)	474,988
Total assets	$ 10,504,507	$ 859,861	$ (88,738)	$ 11,275,630	$ 10,168,414	$ 817,128	$ (33,743)	$ 10,951,799

	June 30, 2014				December 31, 2013			
	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	$ 250,151	$ 21,846	$ (1,975)	$ 270,022	$ 297,322	$ 28,880	$ (1,188)	$ 325,014
Compensation and amounts withheld from payroll	286,101	8,293	-	294,394	248,667	7,482	-	256,149
Current portion of long-term debt	49,281	4,614	-	53,895	47,546	4,952	-	52,498
Variable rate debt classified as current	421,240	66,850	-	488,090	421,380	66,850	-	488,230
Due to affiliates	12,707	15,605	(28,312)	-	-	2,390	(2,390)	-
Other current liabilities	309,802	65,374	(19,578)	355,598	329,074	73,266	(20,791)	381,549
Total current liabilities	1,329,282	182,582	(49,865)	1,461,999	1,343,989	183,820	(24,369)	1,503,440
Long-term debt:								
Hospital revenue bonds	2,300,079	-	-	2,300,079	2,343,380	0	-	2,343,380
Notes payable and capital leases	74,640	18,529	(8,221)	84,948	73,759	18,793	(5,926)	86,626
	2,374,719	18,529	(8,221)	2,385,027	2,417,139	18,793	(5,926)	2,430,006
Other liabilities:								
Professional and general insurance liability reserves	55,890	89,661	-	145,551	55,794	77,382	-	133,176
Accrued retirement benefits	252,004	-	-	252,004	263,259	-	-	263,259
Other noncurrent liabilities	432,592	33,864	(27,204)	439,252	406,414	7,098	-	413,512
	740,486	123,525	(27,204)	836,807	725,467	84,480	-	809,947
Total liabilities	4,444,487	324,636	(85,290)	4,683,833	4,486,595	287,093	(30,295)	4,743,393
Net assets:								
Unrestricted	5,341,876	474,813	(3,448)	5,813,241	5,012,344	470,031	(3,448)	5,478,927
Temporarily restricted	468,660	34,344	-	503,004	426,843	34,267	-	461,110
Permanently restricted	249,484	26,068	-	275,552	242,632	25,737	-	268,369
Total net assets	6,060,020	535,225	(3,448)	6,591,797	5,681,819	530,035	(3,448)	6,208,406
Total liabilities and net assets	$ 10,504,507	$ 859,861	$ (88,738)	$ 11,275,630	$ 10,168,414	$ 817,128	$ (33,743)	$ 10,951,799

See notes to unaudited consolidated financial statements.

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

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

Operations

	Three Months Ended June 30, 2014				Three Months Ended June 30, 2013			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group As Adjusted (See Note 4)	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated As Adjusted (See Note 4)
Unrestricted revenues								
Net patient service revenue	$ 1,584,577	$ 62,544	$ (55,658)	$ 1,591,463	$ 1,572,823	$ 63,716	$ (49,304)	$ 1,587,235
Provision for uncollectible accounts	(100,089)	(3,407)	-	(103,496)	(104,638)	(4,014)	-	(108,652)
Net patient service revenue less provision for uncollectible accounts	1,484,488	59,137	(55,658)	1,487,967	1,468,185	59,702	(49,304)	1,478,583
Other	126,864	60,654	(31,799)	155,719	122,592	64,306	(30,052)	156,846
Total unrestricted revenues	1,611,352	119,791	(87,457)	1,643,686	1,590,777	124,008	(79,356)	1,635,429
Expenses								
Salaries, wages, and benefits	931,716	52,300	(63,796)	920,220	909,424	54,731	(56,427)	907,728
Supplies	141,172	13,127	(345)	153,954	151,003	13,104	(267)	163,840
Pharmaceuticals	137,949	3,267	-	141,216	117,355	3,507	-	120,862
Purchased services and other fees	84,116	8,635	(3,222)	89,529	94,461	9,201	(3,047)	100,615
Administrative services	34,572	14,114	(5,771)	42,915	30,626	15,757	(6,154)	40,229
Facilities	69,560	6,978	(1,422)	75,116	68,967	7,675	(1,365)	75,277
Insurance	15,302	16,548	(12,901)	18,949	14,195	13,193	(12,096)	15,292
	1,414,387	114,969	(87,457)	1,441,899	1,386,031	117,168	(79,356)	1,423,843
Operating income before interest, depreciation, and amortization expenses	196,965	4,822	-	201,787	204,746	6,840	-	211,586
Interest	25,585	512	-	26,097	26,255	534	-	26,789
Depreciation and amortization	91,606	5,201	-	96,807	89,559	5,190	-	94,749
Operating income (loss)	79,774	(891)	-	78,883	88,932	1,116	-	90,048
Nonoperating gains and losses								
Investment gain (loss)	167,399	8,786	-	176,185	(13,187)	(616)	-	(13,803)
Derivative (losses) gains	(18,982)	(779)	-	(19,761)	34,871	(775)	-	34,096
Other, net	128	-	-	128	156	(50)	-	106
Net nonoperating gains and losses	148,545	8,007	-	156,552	21,840	(1,441)	-	20,399
Excess of revenues over expenses	228,319	7,116	-	235,435	110,772	(325)	-	110,447

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

($ in thousands)

Changes in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at April 1, 2013	$ 4,763,098	$ 517,575	$ (3,448)	$ 5,277,225
Excess of revenues over expenses, *as adjusted (see Note 4)*	110,772	(325)	-	110,447
Donated capital, excluding assets released from restrictions for capital purposes	246	-	-	246
Restricted gifts and bequests	8,688	660	-	9,348
Restricted net investment loss	792	142	-	934
Net assets released from restrictions used for operations included in other unrestricted revenues	(6,612)	6	-	(6,606)
Retirement benefits adjustment, *as adjusted (see Note 4)*	(2,273)	-	-	(2,273)
Change in restricted net assets related to interests in foundations	-	263	-	263
Change in restricted net assets related to value of perpetual trusts	450	155	-	605
Net change in unrealized gains on nontrading investments	(432)	-	-	(432)
Other	136	1,816	-	1,952
Increase in total net assets	111,767	2,717	-	114,484
Total net assets at June 30, 2013	$ 4,874,865	$ 520,292	$ (3,448)	$ 5,391,709
Total net assets at April 1, 2014	$ 5,810,524	$ 528,064	$ (3,448)	$ 6,335,140
Excess of revenues over expenses	228,319	7,116	-	235,435
Donated capital, excluding assets released from restrictions for capital purposes	2	-	-	2
Restricted gifts and bequests	25,967	881	-	26,848
Restricted net investment income	9,052	276	-	9,328
Net assets released from restrictions used for operations included in other unrestricted revenues	(6,946)	(1,274)	-	(8,220)
Retirement benefits adjustment	(765)	-	-	(765)
Change in restricted net assets related to interests in foundations	497	-	-	497
Change in restricted net assets related to value of perpetual trusts	566	162	-	728
Net change in unrealized losses on nontrading investments	(7,152)	-	-	(7,152)
Other	(44)	-	-	(44)
Increase in total net assets	249,496	7,161	-	256,657
Total net assets at June 30, 2014	$ 6,060,020	$ 535,225	$ (3,448)	$ 6,591,797

See notes to unaudited consolidated financial statements.

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

Unaudited Consolidating Statements of Operations and Changes in Net Assets

($ in thousands)

Operations

	Six Months Ended June 30, 2014				Six Months Ended June 30, 2013			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group As Adjusted (See Note 4)	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated As Adjusted (See Note 4)
Unrestricted revenues								
Net patient service revenue	$ 3,128,473	$ 128,713	$ (104,597)	$ 3,152,589	$ 3,113,512	$ 130,466	$ (93,352)	$ 3,150,626
Provision for uncollectible accounts	(202,082)	(7,256)	-	(209,338)	(206,064)	(7,841)	-	(213,905)
Net patient service revenue less provision for uncollectible accounts	2,926,391	121,457	(104,597)	2,943,251	2,907,448	122,625	(93,352)	2,936,721
Other	239,517	107,431	(61,617)	285,331	243,635	109,012	(58,201)	294,446
Total unrestricted revenues	3,165,908	228,888	(166,214)	3,228,582	3,151,083	231,637	(151,553)	3,231,167
Expenses								
Salaries, wages, and benefits	1,864,342	104,917	(119,317)	1,849,942	1,814,648	106,413	(106,969)	1,814,092
Supplies	280,293	21,926	(470)	301,749	300,591	21,427	(414)	321,604
Pharmaceuticals	260,056	7,843	-	267,899	229,206	7,727	-	236,933
Purchased services and other fees	170,063	15,384	(6,294)	179,153	180,686	14,421	(6,149)	188,958
Administrative services	63,210	28,760	(11,489)	80,481	56,879	30,363	(11,133)	76,109
Facilities	136,842	13,759	(2,842)	147,759	136,899	14,657	(2,697)	148,859
Insurance	30,180	30,709	(25,802)	35,087	28,546	26,504	(24,191)	30,859
	2,804,986	223,298	(166,214)	2,862,070	2,747,455	221,512	(151,553)	2,817,414
Operating income before interest, depreciation, and amortization expenses	360,922	5,590	-	366,512	403,628	10,125	-	413,753
Interest	51,400	1,002	-	52,402	52,567	1,040	-	53,607
Depreciation and amortization	183,035	10,362	-	193,397	181,198	10,323	-	191,521
Operating income (loss)	126,487	(5,774)	-	120,713	169,863	(1,238)	-	168,625
Nonoperating gains and losses								
Investment return	232,312	12,232	-	244,544	142,634	7,369	-	150,003
Derivative (losses) gains	(41,396)	(1,564)	-	(42,960)	47,269	(1,570)	-	45,699
Other, net	21	(51)	-	(30)	24	(50)	-	(26)
Net nonoperating gains and losses	190,937	10,617	-	201,554	189,927	5,749	-	195,676
Excess of revenues over expenses	317,424	4,843	-	322,267	359,790	4,511	-	364,301

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

($ in thousands)

Changes in Net Assets

	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
Total net assets at January 1, 2013	$ 4,493,222	$ 512,604	$ (3,446)	$ 5,002,380
Excess of revenues over expenses, *as adjusted (see Note 4)*	359,790	4,511	-	364,301
Donated capital, excluding assets released from restrictions for capital purposes	412	-	-	412
Restricted gifts and bequests	34,019	1,447	-	35,466
Restricted net investment income	8,854	496	-	9,350
Net assets released from restrictions used for operations included in other unrestricted revenues	(18,357)	(1,081)	-	(19,438)
Retirement benefits adjustment, *as adjusted (see Note 4)*	(4,546)	-	-	(4,546)
Change in restricted net assets related to interest in foundations	-	263	-	263
Change in restricted net assets related to value of perpetual trusts	877	230	-	1,107
Net change in unrealized gains on nontrading investments	387	-	-	387
Other	207	1,822	(2)	2,027
Increase in total net assets	381,643	7,688	(2)	389,329
Total net assets at June 30, 2013	$ 4,874,865	$ 520,292	$ (3,448)	$ 5,391,709
Total net assets at January 1, 2014	$ 5,681,819	$ 530,035	$ (3,448)	$ 6,208,406
Excess of revenues over expenses	317,424	4,843	-	322,267
Donated capital, excluding assets released from restrictions for capital purposes	2	-	-	2
Restricted gifts and bequests	50,544	1,986	-	52,530
Restricted net investment income	12,148	484	-	12,632
Net assets released from restrictions used for operations included in other unrestricted revenues	(12,781)	(2,303)	-	(15,084)
Retirement benefits adjustment	(1,529)	-	-	(1,529)
Change in restricted net assets related to interests in foundations	677	-	-	677
Change in restricted net assets related to value of perpetual trusts	1,089	331	-	1,420
Net change in unrealized gains on nontrading investments	10,658	-	-	10,658
Other	(31)	(151)	-	(182)
Increase in total net assets	378,201	5,190	-	383,391
Total net assets at June 30, 2014	$ 6,060,020	$ 535,225	$ (3,448)	$ 6,591,797

See notes to unaudited consolidated financial statements.

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

Unaudited Consolidating Statements of Cash Flows

($ in thousands)

	Six Months Ended June 30, 2014				Six Months Ended June 30, 2013			
	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated	Obligated Group	Non-Obligated Group	Consolidating Adjustments & Eliminations	Consolidated
					As Adjusted (See Note 4)			As Adjusted (See Note 4)
Operating activities and net nonoperating gains and losses								
Increase in total net assets	$ 378,201	$ 5,190	$ -	$ 383,391	$ 381,643	$ 7,688	$ (2)	$ 389,329
Adjustments to reconcile increase in net assets to net cash provided by (used in) operating activities and net nonoperating gains and losses:								
Gain on extinguishment of debt	-	-	-	-	(383)	-	-	(383)
Retirement benefits adjustment	1,529	-	-	1,529	4,546	-	-	4,546
Net realized and unrealized gains on investments	(236,844)	(11,709)	-	(248,553)	(132,919)	(6,871)	-	(139,790)
Depreciation and amortization	183,035	10,362	-	193,397	181,198	10,323	-	191,521
Provision for uncollectible accounts	202,082	7,256	-	209,338	206,064	7,841	-	213,905
Donated capital	(2)	-	-	(2)	(412)	-	-	(412)
Restricted gifts, bequests, investment income, and other	(64,458)	(2,801)	-	(67,259)	(43,750)	(2,436)	-	(46,186)
Accreted interest and amortization of bond premiums	(1,266)	-	-	(1,266)	(1,269)	(86)	-	(1,355)
Net loss (gain) in value of derivatives	30,081	-	-	30,081	(58,723)	-	-	(58,723)
Changes in operating assets and liabilities:								
Patient receivables	(274,529)	(11,301)	(1,213)	(287,043)	(277,877)	(6,906)	(2,907)	(287,690)
Other current assets	19,563	(44,169)	53,912	29,306	62,911	(35,116)	26,316	54,111
Other noncurrent assets	(11,867)	(286)	2,296	(9,857)	(2,892)	(260)	1,815	(1,337)
Accounts payable and other current liabilities	(12,069)	2,870	(25,496)	(34,695)	(36,066)	(13,566)	2,349	(47,283)
Other liabilities	(16,591)	39,045	(27,204)	(4,750)	(42,059)	36,789	(25,756)	(31,026)
Net cash provided by (used in) operating activities and net nonoperating gains and losses	196,865	(5,543)	2,295	193,617	240,012	(2,600)	1,815	239,227
Financing activities								
Proceeds from long-term borrowings	-	2,295	(2,295)	-	309,435	1,815	(1,815)	309,435
Payments for advance refunding of long-term debt	-	-	-	-	(287,306)	-	-	(287,306)
Principal payments on long-term debt	(46,098)	(2,897)	-	(48,995)	(45,118)	(4,640)	-	(49,758)
Debt issuance costs	-	-	-	-	(2,129)	-	-	(2,129)
Change in pledges receivable, trusts and interests in foundations	(27,459)	(378)	-	(27,837)	10,146	(539)	-	9,607
Restricted gifts, bequests, investment income, and other	64,458	2,801	-	67,259	43,750	2,436	-	46,186
Net cash (used in) provided by financing activities	(9,099)	1,821	(2,295)	(9,573)	28,778	(928)	(1,815)	26,035
Investing activities								
Expenditures for property and equipment	(163,273)	(12,592)	-	(175,865)	(143,602)	(1,701)	-	(145,303)
Net change in cash equivalents reported in long-term investments	(93,420)	1,599	-	(91,821)	64,570	10,755	-	75,325
Purchases of investments	(702,804)	(48,948)	-	(751,752)	(891,776)	(53,860)	-	(945,636)
Sales of investments	805,942	42,213	-	848,155	743,016	56,225	-	799,241
Net cash (used in) provided by investing activities	(153,555)	(17,728)	-	(171,283)	(227,792)	11,419	-	(216,373)
Increase (decrease) in cash and cash equivalents	34,211	(21,450)	-	12,761	40,998	7,891	-	48,889
Cash and cash equivalents at beginning of year	-	70,900	-	70,900	6,756	76,037	-	82,793
Cash and cash equivalents at end of period	$ 34,211	$ 49,450	$ -	$ 83,661	$ 47,754	$ 83,928	$ -	$ 131,682

See notes to unaudited consolidated financial statements.

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

Utilization

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

CLEVELAND CLINIC HEALTH SYSTEM

	Year Ended December 31			YTD June 30	
	2011	**2012**	**2013**	**2013**	**2014**
Total Staffed Beds[1]	3,403	3,572	3,535	3,550	3,562
Percent Occupancy[1]	68.7%	68.8%	67.7%	69.6%	66.8%
Inpatient Admissions[1]					
Acute	147,294	144,495	144,421	73,430	69,101
Post-acute	13,330	12,899	12,676	5,853	5,933
Total	160,624	157,394	157,097	79,283	75,034
Patient Days[1]					
Acute	768,397	766,940	756,225	387,881	366,990
Post-acute	114,385	109,133	102,653	49,687	49,396
Total	882,782	876,073	858,878	437,568	416,386
Average Length of Stay					
Acute	5.22	5.29	5.24	5.26	5.29
Post-acute	8.56	8.42	8.10	8.50	8.63
Surgical Facility Cases					
Inpatient	58,930	56,377	57,394	28,794	27,766
Outpatient	124,019	135,973	137,714	68,223	67,662
Total	182,949	192,350	195,108	97,017	95,428
Emergency Room Visits	439,219	458,333	476,144	235,483	233,951
Outpatient Evaluation and Management Visits[2]	2,478,658	2,702,052	2,913,718	1,443,145	1,484,560
Acute Medicare Case Mix Index - Health System	1.83	1.83	1.87	1.87	1.90
Acute Medicare Case Mix Index - Cleveland Clinic	2.51	2.45	2.50	2.51	2.46
Total Acute Patient Case Mix Index - Health System	1.74	1.76	1.79	1.78	1.81
Total Acute Patient Case Mix Index - Cleveland Clinic	2.34	2.32	2.35	2.35	2.37

[1] Acute and post-acute, including rehabilitative and psychiatric services within post-acute, but excluding newborns and bassinets.
[2] Statistic is calculated based on Cleveland Clinic only.

Utilization (continued)

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

TOTAL OBLIGATED GROUP

	Year Ended December 31			YTD June 30	
	2011	**2012**	**2013**	**2013**	**2014**
Total Staffed Beds[1]	3,130	3,297	3,260	3,275	3,294
Percent Occupancy[1]	69.7%	70.0%	69.0%	71.0%	68.0%
Inpatient Admissions[1]					
Acute	140,298	137,911	137,920	70,100	66,141
Post-acute	11,192	10,604	10,438	4,756	4,863
Total	151,490	148,515	148,358	74,856	71,004
Patient Days[1]					
Acute	739,682	740,927	731,457	375,176	355,456
Post-acute	86,603	79,542	74,113	35,933	35,581
Total	826,285	820,469	805,570	411,109	391,037
Surgical Facility Cases					
Inpatient	56,585	54,247	55,395	27,805	26,866
Outpatient	120,362	132,406	134,579	66,660	66,247
Total	176,947	186,653	189,974	94,465	93,113
Emergency Room Visits	405,712	423,159	442,487	218,728	218,311
Outpatient Evaluation and Management Visits[2]	2,478,658	2,702,052	2,913,718	1,443,145	1,484,560
Acute Medicare Case Mix Index	1.79	1.79	1.83	1.82	1.85
Total Acute Patient Case Mix Index	1.70	1.71	1.74	1.73	1.76

(1) Acute and post-acute, including rehabilitative and psychiatric services within post-acute, but excluding newborns and bassinets.
(2) Statistic is calculated based on Cleveland Clinic only.

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

Payor Mix

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

CLEVELAND CLINIC HEALTH SYSTEM
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD June 30	
	2011	2012	2013	2013	2014
Payor					
Managed Care and Commerical	44%	43%	43%	43%	43%
Medicare	42%	43%	43%	43%	43%
Medicaid	8%	8%	8%	8%	9%
Self-Pay & Other	6%	6%	6%	6%	5%
Total	100%	100%	100%	100%	100%

OBLIGATED GROUP
Based on Gross Patient Service Revenue

	Year Ended December 31			YTD June 30	
	2011	2012	2013	2013	2014
Payor					
Managed Care and Commerical	44%	43%	43%	43%	43%
Medicare	42%	43%	43%	43%	43%
Medicaid	8%	8%	8%	8%	9%
Self-Pay & Other	6%	6%	6%	6%	5%
Total	100%	100%	100%	100%	100%

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

Research Support

($ in thousands)

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

	Year Ended December 31			YTD June 30	
	2011	**2012**	**2013**	**2013**	**2014**
External Grants Earned					
Federal Sources	$111,404	$107,284	$106,211	$55,589	$49,668
Non-Federal Sources	74,097	72,008	72,316	36,696	42,794
Total	185,501	179,292	178,527	92,285	92,462
Internal Support	69,659	72,133	67,198	32,136	34,913
Total Sources of Support	$255,160	$251,425	$245,725	$124,421	$127,375

Key Ratios

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

	Year Ended December 31			YTD June 30	
	2011	**2012**	**2013**	**2013**	**2014**
Liquidity ratios					
Days of cash on hand	259	284	323	305	338
Days of revenue in accounts receivable	46	49	48	51	52
Coverage ratios					
Cash to debt (%)	140.8	146.9	172.6	161.5	185.1
Maximum annual debt service coverage (x)	5.3	4.4	5.6	5.0	5.3
Interest expense coverage (x)	9.3	8.3	10.4	9.2	10.0
Debt to cash flow (x)	3.4	3.9	3.0	3.3	3.1
Leverage ratio					
Debt to capitalization (%)	41.4	40.9	35.2	38.8	33.5
Profitability ratios					
Operating margin (%)	5.0	2.5	4.6	5.2	3.7
Operating cash flow margin (%)	12.9	10.3	11.7	12.8	11.4
Excess margin (%)	3.5	9.2	12.8	10.6	9.4
Return on assets (%)	2.2	6.0	8.2	6.7	5.7

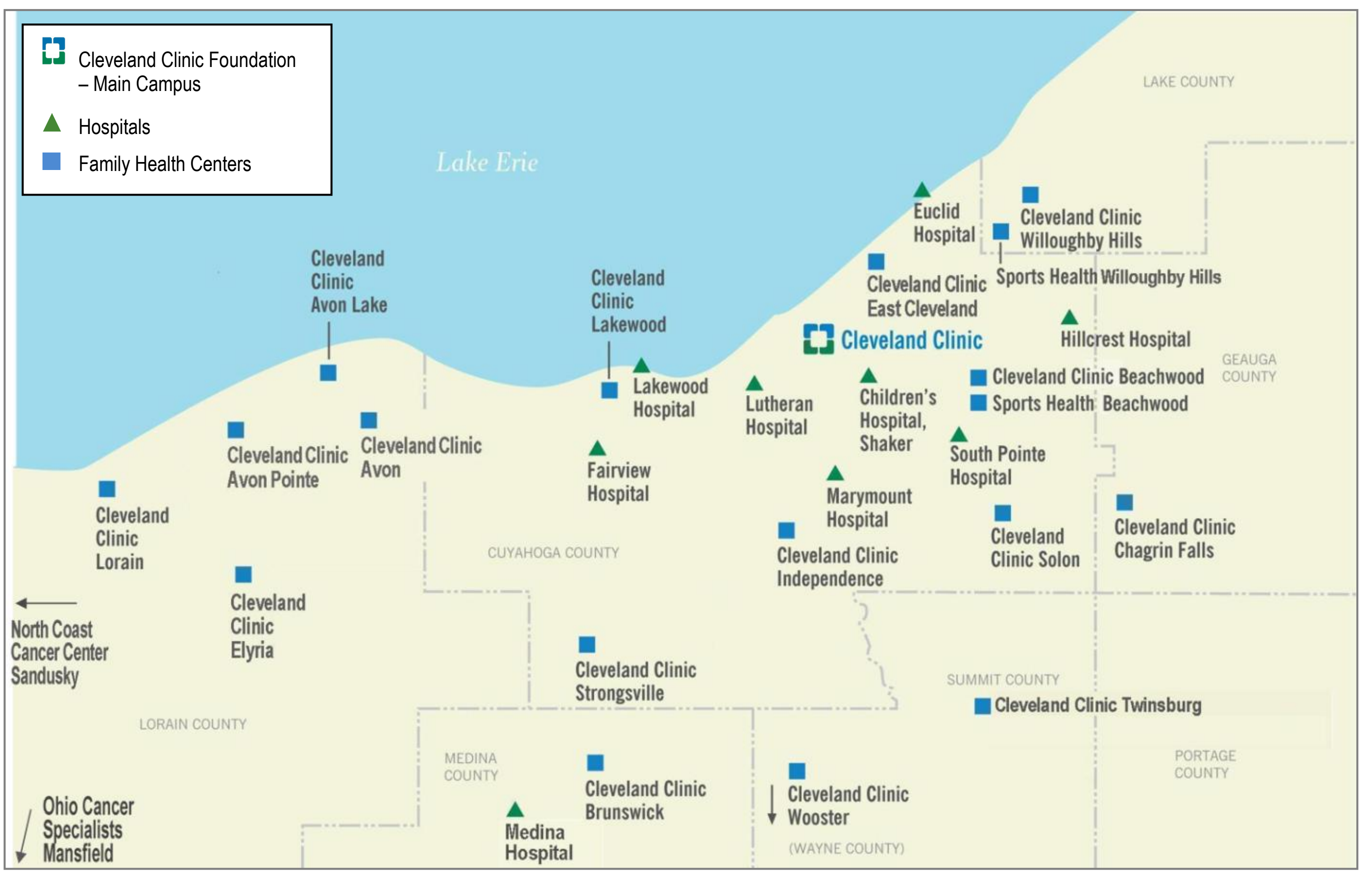
NOTES:

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

OVERVIEW

The Cleveland Clinic Health System (System) is a world-renowned provider of healthcare services, which attracted patients from across the United States and from 133 other countries in 2013. The System is the leading provider of healthcare services in northeast Ohio. The System operates eleven hospitals with approximately 3,600 staffed beds. Ten of the hospitals are operated in the Cleveland metropolitan area, anchored by The Cleveland Clinic Foundation (Clinic). The System operates eighteen outpatient Family Health Centers, ten ambulatory surgery centers, as well as numerous physician offices located throughout a seven-county area of northeast Ohio. In addition, the System operates a hospital and a clinic in Weston, Florida, health and wellness centers in West Palm Beach, Florida and Toronto, Canada, a specialized neurological clinical center in Las Vegas, Nevada, and specialized cancer centers in Sandusky and Mansfield, Ohio. Pursuant to agreements, the System also provides management services for Ashtabula County Medical Center, located in Ashtabula, Ohio, with approximately 180 staffed beds, and in cooperation with Abu Dhabi Health Services Company, the Sheikh Khalifa Medical City, a network of healthcare facilities in Abu Dhabi, United Arab Emirates with approximately 760 staffed beds.

CLEVELAND CLINIC HEALTH SYSTEM
NORTHEAST OHIO SERVICE AREA AND FACILITIES



The following table sets forth the number of staffed beds for the hospitals currently operated by the obligated group as well as the other entities in the System as of June 30, 2014:

	Staffed Beds
OBLIGATED	
Cleveland Clinic	1,274
Euclid Hospital	219
Fairview Hospital	426
Hillcrest Hospital	447
Lutheran Hospital	198
Marymount Hospital	284
Medina Hospital	136
South Pointe Hospital	155
Weston Hospital	155
	3,294
NON-OBLIGATED	
Children's Hospital, Shaker	25
Lakewood Hospital	243
	268
HEALTH SYSTEM	3,562

AWARDS & RECOGNITION

The Clinic was ranked as the fourth best hospital in the United States by *U.S. News and World Report* in its 2014-2015 edition of "America's Best Hospitals." This is the eleventh consecutive year the Clinic was ranked among the top four hospitals in the United States. The Clinic's Heart and Vascular Institute, located on the Clinic's main campus, was recognized as the best cardiology and heart surgery program in the United States, an honor the Clinic has received annually for twenty consecutive years. The Clinic has additionally received the honor of being recognized with the best urology program in the United States. This program ranked second in the United States last year. The report ranked twelve other Clinic medical specialties among the nation's Top 15: diabetes & endocrinology (2), gastroenterology and GI surgery (2), nephrology (2), rheumatology (2), gynecology (3), orthopedics (3), pulmonology (3), ear, nose & throat (6), neurology and neurosurgery (6), ophthalmology (7), geriatrics (9) and cancer (13).

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 all ten medical specialties ranked by *U.S. News and World Report*. The Children's Hospital ranked in seven specialties last year. Pediatric specialties ranked by *U.S. News and World Report* include cancer, cardiology & heart surgery, diabetes & endocrinology, gastroenterology & GI surgery, neonatology, nephrology, neurology & neurosurgery, orthopedics, pulmonology, and urology.

The publication also evaluated hospitals by metropolitan area with a methodology similar to that used to determine the national rankings. The Clinic was ranked as the best hospital in both the state of Ohio and the Cleveland metropolitan area, which includes the City of Cleveland and its surrounding suburbs. The report also ranked six of the System's community hospitals in the top 10 of Cleveland-area hospitals: Fairview Hospital (4), South Pointe Hospital (6), Marymount Hospital (7), and Euclid Hospital, Lutheran Hospital and Medina Hospital (tied for 9). Weston Hospital was ranked third in the Miami-Fort Lauderdale metro area and thirteenth in the state.

The Clinic has been named one of the World's Most Ethical Companies by the Ethisphere Institute for the fourth time in six years. The 2014 award winners are companies that promote ethical business practices, exceed minimum legal requirements, and shape future industry standards. Companies were evaluated in five categories: ethics and compliance programs; reputation, leadership and innovation; governance; corporate citizenship and responsibility; and culture of ethics.

The Clinic received Healthgrades' 2014 Outstanding Patient Experience Award. Recipients of this award were chosen for providing outstanding performance in the delivery of positive experiences for patients based on hospitals' HCAHPS patient survey scores. Healthgrades grouped eligible hospitals into five categories. Hospitals in the top fifteen percent of their respective category received the award. In addition, Healthgrades recognized Marymount and South Pointe Hospitals in the list of the top 50 U.S.Hospitals in its annual ranking of quality providers. Hospitals were rated in the categories of patient safety, clinical quality, patient experience, readmission rates and timely and effective care. Healthgrades indicated that those making the top 50 list are in the top one percent of hospitals in the nation providing overall clinical excellence across a broad spectrum of conditions and procedures for a minimum of seven consecutive years.

The Clinic's CEO and President, Delos M. Cosgrove, M.D., was named number one on *Inside Business'* annual Power 100 list of Northeast Ohio's most influential leaders. Dr. Cosgrove has been ranked consistently among the Power 100's Top 3 each year since 2008, and was number one in 2008, 2010, and 2014. The publication cited the System's innovative model of care and worldwide reputation in naming Dr. Cosgrove as the top leader. *Inside Business* compiled the list by surveying the leaders on the previous Power 100 list, in addition to the magazine's assessment of recent events and forces affecting the region.

Several of the System hospitals were recognized by the American Heart Association and the American Stroke Association with "Get with the Guidelines" awards. Euclid, Marymount and South Pointe Hospitals were awarded Silver Plus in the stroke category, and the Clinic and Hillcrest Hospital were awarded Gold Plus in the stroke category. In addition, the Clinic was awarded Gold in the heart failure category. Hospitals receiving Silver and Gold awards follow treatment guidelines in certain key measures at least eighty-five percent of the time and have maintained the performance level for at least twelve months. The Plus award represents an additional seventy-five percent compliance with module specific quality measures.

In February 2014, the Clinic was recognized for being the first hospital in Ohio to implant a leadless pacemaker. This new technology uses nanotechnology that allows the device to operate without wires, called leads, which are a potential cause for complications in traditional pacemakers. The Clinic was also recognized as being one of fewer than five healthcare institutions in the U.S. to perform endoscopic submucosal dissections, a minimally invasive surgery to remove cancerous gastric tumors that are still in early stages.

The Clinic became the first hospital in the U.S. to earn The Joint Commission's Gold Seal of Approval for Primary Care Medical Home (PCMH) certification by demonstrating compliance with the organization's national standards for healthcare quality and safety. The System was evaluated on how effectively primary care clinicians and interdisciplinary teams work in partnership with patients to provide comprehensive, coordinated and patient-centered care. The Clinic's PCMH is a team-based approach to care coordination and population management. Patients benefit from increased access to clinical services and evidence-based treatment protocols while the care provided by other clinicians is tracked and coordinated.

In June, 2014, *The Plain Dealer* newspaper recognized the Clinic as one of Northeast Ohio's 100 top workplaces, ranking it fifteenth in the category for large local employers. This list was based on the opinions of employees who responded to a survey about company values, leadership, compensation, appreciation and work/life balance.

CORPORATE GOVERNANCE

The Board of Directors of the Clinic is responsible for all of its operations and affairs and controls its property. The Board of Directors is also responsible for ensuring that the Clinic is organized, and at all times operated, consistent with its charitable mission and its status as an Ohio nonprofit corporation and tax-exempt charitable organization. The Board of Directors generally meets eight times per year, including an annual meeting during which the Clinic's officers are elected and standing committees are appointed. The size of the Board of Directors can range between 15 to 25 Directors (currently there are 21 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 55 active Trustees and 13 Emeritus Trustees (not including Directors). Directors and Trustees each serve four-year terms and are selected on the basis of their expertise and experience in a variety of areas beneficial to the Clinic. Directors and Trustees are not compensated for their service.

Sheikh Khalifa Medical City, Abu Dhabi

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:

- Audit Committee
- Board Policy Committee
- Compensation Committee
- Conflict of Interest and Managing Innovations Committee
- Finance Committee
- Governance Committee
- Government and Community Relations Committee
- Medical Staff Appointment Committee
- Philanthropy Committee
- Research and Education Committee
- Safety, Quality and Patient Experience Committee

Members of the Committees are chosen based on the interests and skills of the 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.

In 2013, the Clinic and its Community Hospitals approved a new governance model for the community hospitals. The governing boards for the community hospitals were streamlined, and duplicate board committee functions were eliminated. The model also provides for more structured community hospital representation on the Clinic's Board of Directors. New boards of trustees were created for each hospital. These boards meet quarterly and, among other topics, provide local input on quality and patient safety and community health needs.

Brunswick Family Health Center – Brunswick, Ohio

APPOINTMENTS

Joseph Cabral has been appointed Chief Human Resources Officer, effective September 2. Mr. Cabral has more than 20 years of experience in healthcare, having most recently served for the past ten years as Senior Vice President and Chief Human Resources Officer for the North Shore-Long Island Jewish Health System. He has also held key leadership roles at New York Presbyterian Hospital and Children's Hospital in Boston. As Chief Human Resources Officer, Mr. Cabral will lead the human resource activities of the System and direct the development and implementation of workforce programs that will prepare the System for the rapidly changing healthcare environment.

Wael Barsoum, MD, was selected to serve as the Interim President of Cleveland Clinic Florida, replacing Bernie Fernandez, MD who left the System to pursue other opportunities. Dr. Barsoum joined the professional staff of the System in 2003 and most recently served as Chairman of Surgical Operations and Vice Chairman of the Department of Orthopaedic Surgery. He holds a joint appointment in the Department of Biomedical Engineering and is the Director of Research and Education for the Orthopaedic Adult Reconstructive Surgery Section and Associate Professor of Surgery at the Cleveland Clinic Lerner College of Medicine. Dr. Barsoum has written nearly 100 peer-reviewed papers and textbook chapters and has made many national and international presentations. He has received the Cleveland Clinic Foundation Innovations Award six times, including earning the 2011 Sones Award for Innovation.

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 recently completed or in progress:

Radiology Master Plan - This multi-year, multi-phase renovation and construction plan is aimed at fulfilling the growth needs of the Department of Radiology within the Imaging Institute. The project will consolidate and centralize magnetic resonance (MR) services for the Clinic in the Glickman Tower located on the Clinic's main campus. The project also includes the renovation of vacated molecular functional imaging space into a patient preparation and recovery department. Additionally, the plan allows for a new outpatient entrance to the Department of Radiology and enhanced patient waiting and changing areas. Phase 1A of the project, the Interventional MR Surgical Suite, began in 2009 and was completed in 2010. The Suite combines high-field MR imaging with a surgical suite, which allows surgeons to take advantage of MR imaging in real time during surgical procedures. Phase 1B, the consolidation of MR services in the Glickman Tower, began in the fourth quarter 2010 and was completed in July 2011. Phase 2, the consolidation of CT services, was completed in the third quarter of 2013. Construction began on Phase 3, the relocation and upgrade of the Interventional Radiology

Department, in the third quarter of 2013 and is expected to be completed in the first quarter of 2015. The entire project is scheduled to have a total of five phases and is expected to be completed in 2017. The total cost of the project, including the purchase and upgrade of equipment, is approximately $80 million.

Lutheran Hospital Emergency Department Renovation – In the fourth quarter of 2012, Lutheran Hospital began the design of a $17 million replacement, renovation, and expansion of Lutheran's emergency department (ED). The project includes 1,800 square feet of new building space, a 3,800 square foot canopy, and 19,700 square feet of renovated space. The renovation will include an upgrade to the Hospital's main lobby area and a more prominent entrance providing better access to emergency services. The new ED unit will include 21 ED beds, including 6 beds specifically designed for patients with behavioral health needs, a resuscitation room, and 3 intake chairs. The project will include eight phases to allow the ED to remain in operation during the renovation process. Construction started in the second quarter of 2013, and is expected to be completed in 2015.

Brunswick Family Health Center Emergency Department Expansion – In the first quarter of 2013, the Clinic began the design of a new $20 million ED at the Brunswick Family Health Center. The project includes construction of a 39,200 square foot two-story facility adjacent to the existing family health center. The first floor houses the ED, and the second floor is reserved for future expansion. The ED includes eighteen treatment spaces with two fully-equipped critical care rooms, separate drop-off areas and entrances for patients and ambulances, imaging and laboratory services and a rooftop helipad. The ED opened in July 2014 and was named the Ken Cleveland Health Center in honor of a donation from philanthropists Ken and Patricia Cleveland.

Weston Outpatient Clinic Expansion – In the second quarter of 2013, the Clinic began design of a $92 million expansion of the outpatient facilities at the Weston campus. The 143,000 square foot five-story facility will house a Neurological Institute and Cancer Institute, a linear accelerator, advanced radiosurgery technology and a shelled vault for future expansion. Construction started in the fourth quarter of 2013 and is expected to be completed in the first quarter of 2015.

Avon Bed Tower Expansion – In 2013, the Clinic started design of an inpatient bed tower expansion to be located adjacent to the existing Family Health Center in Avon. The planned expansion includes an approximately 213,000 square foot five-story facility with 126 beds. Construction started in the second quarter of 2014 and is expected to be completed in the summer of 2016.

New Cancer Outpatient Building – The Clinic started programming and design of a new Cancer Outpatient Building in 2013. The new building will be located on the Clinic's main campus, adjacent to the Crile Outpatient Building and across from the new Tomsich Pathology Laboratories Building. The 377,000 square foot, seven story building is expected to house 126 exam rooms, 96 infusion bays, 6 linear accelerators, 7 procedure rooms, a Gamma Knife and other support functions for the Clinic's Cancer program. The estimated cost of the new building is $276 million. Construction is expected to start in summer 2014 and be completed in 2017.

Enterprise Administrative Patient Management - The System is currently in the midst of a multi-year project to align revenue cycle support services and processes to support patients as they progress through their continuum of care. The Enterprise Administrative Patient Management (EAPM) project will consolidate thirteen different technology systems used for scheduling appointments, admissions, the electronic medical record, billing and collections into one technology platform with the goal of improving patient experience. Reducing the number of systems will improve patient service and employee efficiency. Implementation of EAPM began in the first quarter of 2012 at the Weston facilities and will continue in phases for the other System facilities over the next several years. EAPM will cost approximately $134 million over the implementation period.

In the second quarter of 2013, the Clinic and Case Western Reserve University (CWRU) School of Medicine reached an agreement to build a health education campus that will contain the university's medical school program and the Cleveland Clinic Lerner College of Medicine. The facility will be located on the Clinic's main campus and will serve as home for the seminar, lecture, and laboratory curriculum taught during the first two years of medical school. Students' clinical training will continue to take place at area hospitals. This initiative is aligned with the future plans of the Clinic's main campus and supports the Clinic's mission and strategic direction. The full scope of the project is currently under review, with the potential for additional medical education facilities. Construction of the new campus is expected to begin in 2014 and take approximately four years to complete. CWRU and the Clinic will share in the construction and ongoing operational costs of the facility, with a portion of the construction costs expected to be raised through fundraising efforts and donations.

Cleveland Skyline – Cleveland, Ohio

PHILANTHROPY CAMPAIGN

In June 2014, the Clinic publicly launched "The Power of Every One" philanthropic campaign, with a goal of raising $2 billion by the Clinic's 100th anniversary in 2021. The campaign will enable the organization to transform patient care, promote health, advance research and innovation, train caregivers and revitalize facilities through new construction and renovation of existing buildings. The Clinic already has raised more than $600 million toward the goal.

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

INNOVATIONS

Cleveland Clinic Innovations promotes scientific, clinical and administrative creativity throughout the Clinic and seeks commercial application of that creativity. Specifically, it helps to grow the Clinic's innovative capacity, mentors inventors, licenses technology, secures resources, and establishes spin-off companies and strategic collaborations with corporate partners. Since 2000, 67 companies, of which more than 48 are currently active and employing over 500 people, have been spun-off from the Clinic (including two initial public offerings and three commercial exits). Cleveland Clinic Innovations has entered into more than 450 technology licenses, filing 2,478 patent applications with over 600 issued patents, and acted on approximately 2,600 new inventions. In 2010, Cleveland Clinic Innovations opened a new 50,000 square foot Global Cardiovascular Innovation Center on the Clinic's main campus, which is home to its operations, as well as an incubator facility for approximately 20 other companies.

CardioMEMs, Inc., a Clinic spin-off company, completed its previously announced acquisition by St. Jude Medical in May 2014 after receiving FDA approval for its CardioMEMS™ HF System. The technology, which utilizes a MEMS-based, wireless monitoring sensor, is the first of its kind to measure right heart pressure to support pharmacological management of congestive heart failure patients. The CardioMEMS sale marks the ninth monetization of a Clinic spin-off company.

In July 2014, Parker Hannifin Corporation, a global leader in motion and control technologies, announced it is developing more than 100 potential medical advancements with the Clinic. The collaboration combines Parker's engineering and new product development expertise with the Clinic's clinical and research abilities and unique understanding of the need for innovative medical solutions to address challenges in modern healthcare. Several of the medical solutions have been submitted for regulatory approval in Europe and the U.S. and are anticipated to be ready for commercial launch as early as 2015.

Cleveland Clinic Innovations will be hosting the 12th Annual Medical Innovation Summit in October 2014 at the Cleveland Convention Center Global Center for Health Innovation in downtown Cleveland. The Summit generally draws over 1,500 attendees, including industry leaders, investors, and entrepreneurs looking to expand their understanding of the healthcare market and the future of medical innovation. The focus of this year's summit will be the future of cancer treatment and personalized medicine.

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.

During the first quarter of 2014, the Clinic's Sydell and Arnold Miller Family Heart & Vascular institute entered into three new affiliation agreements. In January, it entered into affiliation agreements with Saint Francis Medical Center in Missouri and Christus St. Michael Health System in Texas. In February, it entered into an affiliation agreement with Susquehanna Health in Pennsylvania. Under the terms of the affiliation agreements, the Clinic will collaborate with these institutions on clinical, academic, and research activities in their cardiac programs. The latest affiliation agreement with Susquehanna Health brings the total Heart & Vascular institute affiliations to twenty-two, including three in Pennsylvania.

JOINT VENTURE

In June 2014, the Clinic announced a joint venture with Select Medical to expand inpatient rehabilitation services in Northeast Ohio and improve access for patients with complex rehab needs. Select Medical is the nation's largest provider of post-acute services and has successful partnerships with academic medical centers around the country. As part of the joint venture, a new 60-bed adult inpatient rehabilitation hospital will be built in Avon, near the Avon medical campus. The new facility is expected to open in late 2015. The two organizations have also entered into a management agreement effective in August 2014 to enhance inpatient rehabilitation operations in existing System facilities. Additionally, the new joint venture will establish a residency program for physicians in physical medicine and rehabilitation.

CLINICAL INVESTMENT

In June 2014, the Clinic and Akron General Health System (Akron General) signed a letter of intent to enter into an exclusive agreement to make the Clinic a minority owner of Akron General. In addition to its flagship Akron General Medical Center, a 532 registered bed teaching and research medical center, Akron General includes Lodi Community Hospital, an inpatient and outpatient rehabilitation facility, various health and wellness centers, a physician group practice and other outpatient locations. *U.S. News & World Report* recently ranked Akron General Medical Center as the fifth best hospital in Ohio. In 2013, the American Nurses Association awarded the prestigious "Magnet" status to Akron General Medical Center and certain of its affiliates. The agreement will combine clinical expertise and resources of the Clinic and Akron General with the goal of strengthening and improving access to high-quality, affordable healthcare for patients in Akron and the surrounding region.

As a provision of the agreement, the Clinic will make a substantial capital investment in Akron General. Another key provision of the agreement is the addition of Akron General's physicians into the Clinic's Quality Alliance, a network of independent and employed physicians working to improve quality of care, reduce costs, increase efficiency, and provide access to expertise, data and experience.

STRATEGY

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

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

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

- Care Paths across the continuum to reduce practice variation, improve quality outcomes, lower costs and improve efficiency – multiple pilots are currently underway to test Care Paths in practice, with goals of quality improvement and cost reduction
- Shared savings agreements with payors to incent improved outcomes - collaborative discussions are underway with major health plans as the System transitions from a fee-based to a value-based payment structure
- Quality alliances to further integrate care protocols and measurements beyond the Clinic's physician group
- Advanced technology infrastructure to enhance predictive capabilities and knowledge management
- Cost reduction, resource rationalization and asset optimization to drive efficiency

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

As the System continues to evolve, its mission remains at the core. The decision to invest in a state-of-the-art medical facility is illustrative of the continued focus on the System's mission. The health education campus will benefit the System, as well as the greater Cleveland community by establishing a pipeline that will draw top healthcare talent to the area.

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

COMMUNITY BENEFIT AND ECONOMIC IMPACT

Community Benefit

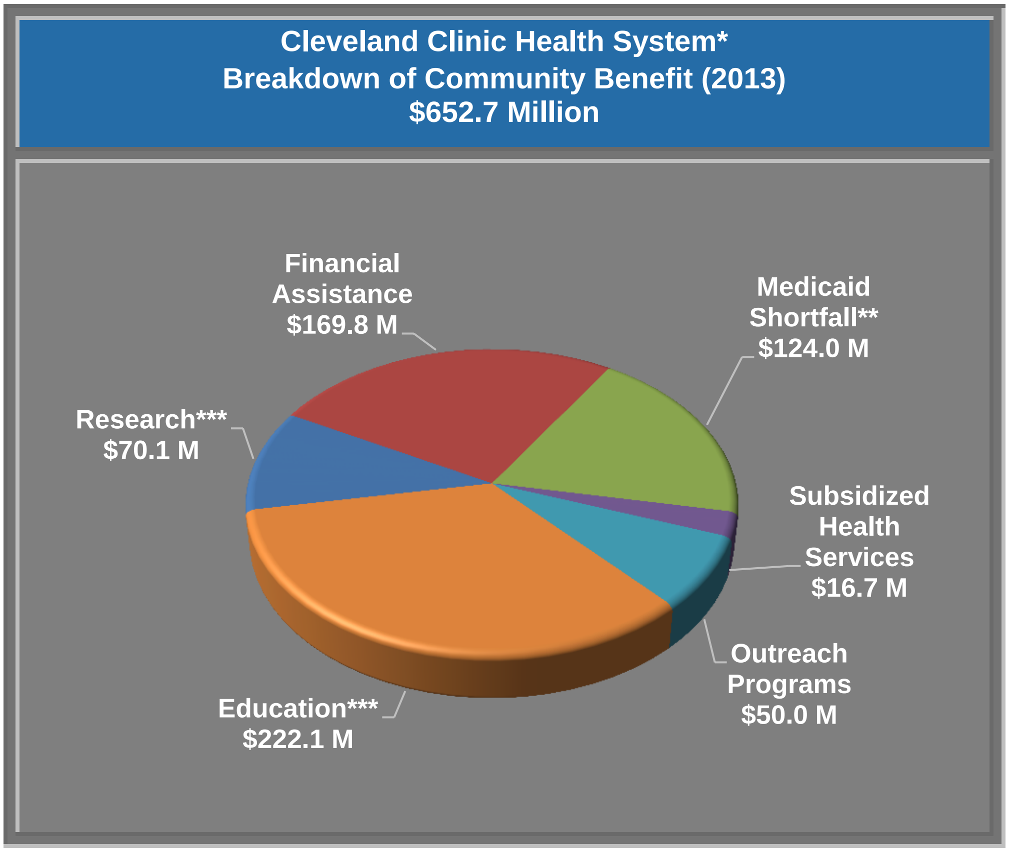
The Clinic and its hospital affiliates within the System are charitable, tax-exempt healthcare organizations. The System's mission includes addressing health service needs and providing benefits to the communities it serves. Each hospital in the System must satisfy a community benefit standard to maintain its tax-exempt status. To measure the cost of the benefits the System provides to the community, the System uses the Catholic Health Association (CHA) community benefit model, the national standard for community benefit reporting.

The System has been reporting community benefit since 2005 in accordance with CHA standard definitions and methodology. In 2008, the IRS began requiring all nonprofit hospitals to report community benefit on the revised Form 990, using a methodology that closely follows CHA standards. The IRS Form 990 is the information return required to be filed with the IRS by exempt organizations.

In 2013, the IRS started to instruct nonprofit hospitals to report community benefit expenses after reduction for externally sponsored funding. The System is reporting community benefit for 2013 in accordance with this new IRS guidance.

COMMUNITY BENEFIT

The following chart summarizes the benefits provided by the System in 2013 to the communities it serves.



* Includes all System operations in Ohio, Florida and Nevada
** Net of HCAP benefit of $17.7 million
*** Research and Education are supported by externally sponsored funding of $142.0 million.

Financial Assistance: Financial Assistance represents the cost of providing free or discounted medically necessary care to patients unable to pay some or all of their medical bills. The System's financial assistance policy provides free or discounted care to uninsured patients whose incomes are up to 400 percent of the federal poverty level and who meet certain other eligibility criteria by state. This policy includes covered 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. The Langston Hughes Health and Education Center, a Fairfax neighborhood site, provided multigenerational prevention and wellness services.
- Health fairs provided thousands of people with free screenings for diabetes, cholesterol, heart disease, and prostate and various cancers. The Cleveland Clinic Minority Men's Health Fair, Celebrating Sisterhood, Tu Familia and dozens of community health fairs educated community members on the benefits of preventive healthcare.
- Community education classes were offered across the enterprise providing education on chronic disease management in the areas of heart disease, stroke, cancer, diabetes and brain health.
- Wellness initiatives and health lectures were provided to schools, faith-based organizations and community centers in the areas of prevention and behavioral change, including smoking cessation, weight management, teen parenting, family violence and child safety.
- Physical education, training and concussion awareness were provided to high school students by the Clinic's Orthopaedic and Rheumatology Institute.
- The Clinic's Robert J. Tomsich Pathology & Laboratory Medicine Institute donated services to Cleveland area safety-net providers, The Free Clinic and Care Alliance.

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. Allied health professionals are also recognized as important members of the healthcare team.

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

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

Community Health Needs Assessment

In the third quarter of 2013, the System completed comprehensive community health needs assessments (CHNA) for each of the hospitals in the System. Internal Revenue Code Section 501(r)(3) requires nonprofit hospital organizations to conduct a CHNA every three years and adopt an implementation strategy to identify the community health needs the hospital will address.

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

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

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

Key CHNA needs identified throughout the System include:

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

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

Economic Impact

According to the System's 2010 Economic and Fiscal Impact Report released in 2011, the System is the largest employer in Northeast Ohio and the second largest employer in the State of Ohio with more than 41,000 employees. In 2009 the System generated $10.5 billion of the total economic activity in Ohio ($10.4 billion on a regional level), and has directly and indirectly supported more than 81,000 jobs generating approximately $4.0 billion in wages and earnings. The System's economic activity was accountable for $663 million in total state and local taxes. System-supported households spent $2.3 billion on goods and services. Locally, the System's economic activity within an eight-county region accounts for approximately eight percent of the total gross regional product. As a major part of the region's growing healthcare industry, the System has contributed to the strengthening of Ohio's economy for the past 90 years by sustaining and growing a strong workforce.

The System's 2010 Economic and Fiscal Impact Report is the result of an economic analysis completed by the Cleveland-based Silverlode Consulting Corp. The report was commissioned in 2010 and used 2009 data, the most current data available at that time. The report was completed in part using the IMPLAN® economic impact model, which is used by more than 1,000 public and private institutions to estimate economic and fiscal impacts. The 2010 Economic and Fiscal Impact Report is the most recent report available for the System.

SUSTAINABILITY

The System supports healthy environments for healthy communities. Through its operations and community leadership, the System takes a precautionary approach to environmental stewardship with the understanding that environmental health and human health are closely linked. In 2007, the System created the Office for a Healthy Environment (OHE). The OHE's purpose is to create a healthcare system that is ecologically, socially, and economically sustainable and avoids harm to human health and the environment. OHE goals are aligned with the mission and values of the System, and sustainability policies are embedded in the construction, maintenance and operation of facilities across the System. The OHE works cross-functionally and enterprise-wide to mitigate resource consumption intensity, identify and pursue new opportunities and educate caregivers.

The System has publically committed to compiling a sustainability report through two leading international frameworks: The United Nations Global Compact and the Global Reporting Initiative (GRI). The System compiles this report for its patients, caregivers, communities and global stakeholders. As a leader in the healthcare industry, the System is accountable for its social, environmental and economic impacts. The System develops this report to share its performance metrics and stories, to highlight its accomplishments and to communicate its challenges as it strives to reach its goals.

This year marks the fifth consecutive Communication on Progress report and reflects work based on the 2013 calendar year. In addition to addressing the 10 principles of the United Nations Global Compact, this report applies the Global Reporting Initiative's G3.1 guidelines, the world's most common standard for sustainability reporting. As a signatory to the United Nations Global Compact, the System has pledged to promote sustainability policies and practices to advance the organization in ways that benefit the economies and societies it serves.

To align the System's reporting process with its environmental stewardship goals, an online report has been developed this year. The complete sustainability report is available on the Clinic's website at: *www.clevelandclinic.org/ungc*.

The Clinic is a member of Practice Greenhealth (PGH), a national membership organization for healthcare facilities committed to environmentally responsible operations. Practice Greenhealth empowers its members to increase their efficiencies and environmental stewardship while improving patient safety and care through tools, best practices and knowledge. In 2014, the Clinic, Euclid Hospital, Stephanie Tubbs Jones Health Center and Richard E. Jacobs Health Center were awarded the prominent Greenhealth Emerald Award by Practice Greenhealth. In addition to four Emerald Awards, the System was honored with twenty-two additional Practice Greenhealth Environmental Excellence Awards for outstanding performance in health care sustainability, including the System for Change Award, Circles of Excellence in Greening the OR, Green Building and Water. Practice Greenhealth Environmental Excellence Awards recognize health care facilities, business and organizational members for their demonstrated commitment to minimizing their environmental footprint by incorporating sustainability into their day-to-day operations.

The Practice Greenhealth Environmental Excellence Awards were presented in Cleveland, Ohio, in June at the CleanMed Conference & Exhibition, the premier national environmental conference for leaders in health care sustainability. The Clinic played a significant leadership role in the conference, including sponsorship and leadership in seven panel presentations.

The System joined the Department of Energy's (DOE) Better Buildings Challenge as a challenge partner in 2011, committing the System to a 20 percent reduction in energy usage by 2020. Participation in the Better Buildings Challenge allows the System to track, manage and save energy as well as providing open forums for the System to share its initiatives and to learn from other partners. Additionally, the System has set a goal of $12 million in energy demand reduction targets across the enterprise through its cost repositioning initiative. Projects include a combination of critical energy efficiency projects and broad occupant education and engagement campaigns.

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

The System currently has thirteen LEED-certified buildings, with additional buildings pending certification. The System has four buildings that are certified LEED-Gold, including the recently constructed Marymount Hospital Surgical Expansion, Twinsburg Health and Family Surgery Center and the Robert J. Tomsich Pathology and Laboratory Medicine Institute building. Additionally, the System has seven buildings that are certified LEED-Silver.

DIVERSITY

The System provides healthcare services to patients and families from a global community. This makes diversity, inclusion and cultural competence a critical part of the System's mission. In 2007, the System created the Office of Diversity and Inclusion (Diversity). Diversity's mission is to provide strategic direction that builds cultural competence, cultivates an inclusive organization, develops talent, and supports caregivers to better serve our patients. Its programs include cultural competence training, diversity councils, employee resource groups, language enrichment, and pipeline development programs for high school and college students.

In 2014, the System was named one of the country's top five healthcare organizations for diversity management practices by DiversityInc. Rankings are empirically driven and assess performance based on a number of factors including CEO commitment, equitable talent development and spend with certified minority and women businesses. The System was recognized for its CEO leadership in the area of diversity and inclusion, educational pipeline programs for underrepresented minorities in the field of medicine and science and an initiative to develop women to be leaders in medicine.

HEALTH INFORMATION TECHNOLOGY

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

In 2011, the Centers for Medicare & Medicaid Services (CMS) implemented provisions of the Recovery Act that provide annual incentive payments for the meaningful use of certified electronic health record (EHR) technology. CMS has defined meaningful use as meeting certain objectives and clinical quality measures based on current and updated technology capabilities over predetermined reporting periods as established by CMS. The objectives and clinical quality measures are implemented in stages with increasing requirements for participation. The Medicare EHR incentive program provides annual incentive payments to eligible professionals, eligible hospitals, and critical access hospitals, as defined, that are meaningful users of certified EHR technology. In order to qualify for an incentive payment, eligible hospitals and providers need to demonstrate meaningful use of the certified EHR by entering certain objectives and clinical quality measures and attesting that they have successfully demonstrated meaningful use via the CMS' web-based Medicare EHR Incentive Program System. The Medicaid EHR incentive program provides annual incentive payments to eligible professionals and hospitals for efforts to adopt, implement, and meaningfully use certified EHR technology in the first year of participation and successfully demonstrating meaningful use of certified EHR technology in subsequent participation years. Hospitals and providers are required to attest to the EHR requirements on the state's Medicaid Provider Incentive Program. Incentive payments for hospitals are subject to retrospective adjustments after the submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. Annual incentive payments for Medicare and Medicaid are reduced for hospitals and providers in each subsequent year of attestation and are completely phased-out within four to six years of the initial attestation year.

Currently, all of the System's acute care hospitals meet the Medicare meaningful use standards for attestation for Stage 1. Additionally, all of the System's acute care hospitals meet the Medicaid meaningful use standards for attestation for Stage 1 except for Weston Hospital, which currently does not qualify to participate in the Medicaid EHR incentive program. Cleveland Clinic Children's Hospital for Rehabilitation, a non-acute hospital located near the main campus, also meets the Medicaid meaningful use standards for attestation for Stage 1.

CMS recently announced Stage 2 EHR meaningful use requirements, which added new objectives and increased the threshold for many of the objectives in Stage 1. For federal fiscal year 2014, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period. For Medicare providers, this three-month reporting period is fixed to the quarter of either the fiscal year (for eligible hospitals) or calendar year (for eligible physicians). The EHR reporting period for hospitals is based on the federal fiscal year, which runs from October 1 through September 30. System hospitals are required to meet Stage 2 EHR meaningful use requirements in the 2014 federal fiscal year. The System has made all technical and operational changes for Stage 2 requirements and is currently monitoring the compliance of each hospital and provider in the System.

The System utilizes a grant accounting model to recognize EHR incentive revenues. Under this model, the System records EHR incentive revenue ratably throughout the incentive reporting period when it is reasonably assured that it will meet the meaningful use objectives for the required reporting period and that the grants will be received. For the federal fiscal year ending September 30, 2014, System hospitals will record EHR incentive revenue ratably during the three-month reporting period in which the Stage 2 meaningful use standards are met and attested.

The System recorded EHR incentive revenues of $2.5 million in the first six months of 2014 and has recorded a total of $109.4 million since the inception of the program through the end of 2013. Throughout the program, the System is expected to receive approximately $135 million in EHR incentive payments.

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

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

The System participates in the Care Everywhere network, a module offered through Epic Systems Corp. that allows health systems to safely and directly share electronic medical records (EMRs). Through this program, the System has access to a network of over 283 healthcare organizations nationwide. In the past year, the System has exchanged patient information with more than 182 external healthcare organizations in approximately 343,000 cases to assist with treating its patients. This is believed to have improved patient care by immediately providing more complete medical histories, eliminating the need for unnecessary diagnostic tests, allowing for faster and more accurate diagnosis and aiding in criteria required for Stage 2 meaningful use standards. The System collaborates with both local and national hospitals and health systems to link EMRs via Epic. In the third quarter of 2012, Care Everywhere became available at all System locations. In 2013, the System engaged ClinicSync, Ohio's statewide electronic medical records exchange. Participation in CliniSync will link the System to a significant number of hospitals across Ohio. To further broaden its interoperability capabilities, the System has also engaged with Surescripts, a health information service provider that will connect the System to over 200,000 providers across the nation, and eHealth Exchange, the national health exchange hub.

In January 2014, the System merged its electronic medical system, MyPractice, into a single, centralized electronic medical record system that will serve all of the System's facilities. This will enable clinicians who practice in one or more of the System's community hospitals to have a single system with System-wide access for their entire schedule, patient charts, orders and message lists. The consolidation is expected to create efficiencies for clinicians that will improve patient experience.

CONFLICT OF INTEREST

The System maintains policies that require internal reporting of outside financial and fiduciary interests to ensure that potential conflicts of interests do not inappropriately influence research, patient care, education, business or professional decision making. In connection with these policies, the System developed the Innovation Management and Conflict of Interest Program, which is designed to promote innovation while at the same time reducing, eliminating or managing real or perceived bias either due to System personnel consulting with pharmaceutical, medical device and diagnostic companies (industry) or the commercialization efforts undertaken by the System to develop discoveries and make them accessible to patients. The Program works with investigators who interact with industry to manage any conflicts. Provisions related to whether or not "compelling circumstances" are required to justify conducting research in the presence of related financial interests have been relaxed in policies that went into effect on November 1, 2013, consistent with the value the System places on beneficial relationships with industry. The System is committed to a process that maintains integrity in innovation and places the interests of our patients first.

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

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

The System enacted a new Conflict of Interest in Education Policy on November 1, 2013 to more accurately reflect its values and represent its and its Staff's best interests. This new 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 (ACCME) 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 new policy puts the System in step with other top academic medical centers that have already banned speakers 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 community hospitals in the System are required to complete annual disclosure questionnaires each year. These questionnaires are designed to identify possible conflicts of interest that may exist and ensure that any such conflicts do not inappropriately influence the operations of the System. The information obtained from these questionnaires is used to respond to the related-party transactions and other disclosures required by the Internal Revenue Service on Form 990. The Forms 990 for the Clinic and the System for the fiscal year ended December 31, 2012 are available on the Clinic's website, as well as additional information regarding the Clinic's Board of Directors and any business relationships the Directors may have with the System.

ENTERPRISE RISK MANAGEMENT

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

In the ERM process, risk identification is conducted resulting in a System risk profile that categorizes individual risks based on their impact upon the System's ability to meet its strategic objectives. During this process, certain risks are identified as top risks and then further separated into sub-risks and individual risk components. Extensive risk assessments and mitigation analysis are completed 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 as part of this evaluation. The findings of the work teams are reported to senior management, including the Audit Committee of the Board of Directors, the body with oversight responsibility for ERM. ERM is an on-going program and another cycle of risk assessment commenced during the third quarter of 2013. Throughout 2014 the results of these risk assessments will be reviewed and examined by the ERM Steering Committee.

INTERNAL CONTROLS OVER FINANCIAL REPORTING

In 2007, the System began an initiative to evaluate its internal control environment and to create efficiencies in the System's financial reporting processes. The initiative is based upon concepts established in the Sarbanes-Oxley Act of 2002. The goals of the initiative are to ensure the integrity and reliability of financial information, strengthen internal control in the reporting process, reduce the risk of fraud and improve efficiencies in the financial reporting process. The initiative reviews all aspects of the financial reporting process, identifies potential risks and ensures that they have been mitigated utilizing a management self-assessment process. As a result of this initiative, management completed a certification of its internal controls over financial reporting as part of the issuance of its consolidated financial results for 2013, which is the fifth year the certification process was completed. More than 130 members of management, including top leadership, were involved in this certification. The System is one of the first not-for-profit hospitals to issue a management report on the effectiveness of internal controls over financial reporting, a step that further increases the transparency of the organization. Management updates the certification on a quarterly basis. There have been no changes in the internal control over financial reporting during the six months ended June 30, 2014 that have materially affected, or are reasonably likely to materially affect, the internal control over financial reporting for the System.

INDUSTRY OUTLOOK

In November 2013, Moody's Investor Service (Moody's) maintained its negative outlook for the U.S. not-for-profit healthcare sector for 2014, an outlook Moody's has maintained since 2008. Moody's cites three factors to support its negative outlook. The first factor is that revenue growth will slow to a range of 3.0%-3.5%, which is the second consecutive year of decline and a steep drop from the 5.2% growth in fiscal 2012. The primary drivers of slower revenue growth are cuts in Medicare reimbursement, reduced disproportionate share payments, diminished commercial rate increases and lower inpatient volume partially due to shifts to outpatient settings and observations, which are reimbursed at a lower level than inpatient volume. The second factor is that margins will contract as hospitals incur additional costs in information technology and provider networks to adapt to changing reimbursement models and technology requirements related to implementation of electronic medical records and ICD-10. The third factor is the uncertainty stemming from the implementation of the Affordable Care Act, including unknown levels of bad debt and the impact of insurance exchanges on patient volumes and reimbursement rates.

Despite the negative factors noted above, Moody's report acknowledges that many hospitals are resilient and will adapt, as many management teams have proven they can make swift, mid-year changes to adapt to revenue pressures. Moody's report states that mergers and acquisitions may be a path to stability for struggling hospitals. In addition, one positive element of the Affordable Care Act mentioned in the report is the growth of the insured population, particularly in states that have expanded Medicaid eligibility.

In December 2013, Standard & Poor's (S&P) changed its outlook for the U.S. not-for-profit healthcare sector from stable to negative. S&P cites multiple factors to support the negative rating, including top line revenue constraints leading to operating margin compression; the impact of healthcare reform readiness activities; soft patient volumes, particularly for the financially important inpatient business; and the emerging changes in the payment environment from fee-for-service payments to value-based payments. S&P expects many hospitals and health systems to manage the period of change and reform effectively, although all hospitals will be challenged by these industry trends. Positive factors that S&P believes are helping to mitigate rating pressures for organizations include the maintenance of balance sheet strength, implementation of new business models, information technology improvements and state tax programs that help improve Medicaid reimbursement or other healthcare programs.

The System continues to be impacted by industry challenges that put pressure on the System's financial performance. Management is focused on the recruitment and retention of qualified staff in many clinical areas in order to meet the demands of patient activity, particularly as the Affordable Care Act health insurance mandates that are expected to increase the number of insured Americans seeking healthcare services are implemented in 2014. These efforts pressure the System's salary cost structure, as well as employee benefit costs. Pharmaceutical costs and medical supply costs continue to create challenges to the cost structure. Increases in pharmaceutical costs are driven by utilization and price increases. Medical supply costs are primarily driven by utilization and price of implants. For both pharmaceuticals and medical supplies, a sizeable percentage of the cost increase flows through to increases in payments from payors; however, the balance cannot be passed through to payors. Additionally, the healthcare industry is subject to significant regulation by federal, state, and local governmental agencies and independent organizations and accrediting bodies, changes in technology and treatment modes, competition and changes in third-party reimbursement programs. The decline in the population of the Greater Cleveland area, as noted in the 2013 census, creates challenges among hospitals to attract patients. Furthermore, although the System maintains a diversified investment portfolio, the System's investments are subject to the inherent risk and volatility associated with global financial markets. The System continuously monitors the environment in which it operates and is engaged in various strategic initiatives to address its cost structure and reimbursement challenges.

Lakefront
Cleveland, Ohio

PATIENT VOLUMES

The following table summarizes patient volumes for the System:

Utilization Statistics

	For the quarter ended June 30				For the six months ended June 30			
	2014	2013	Variance	%	2014	2013	Variance	%
Inpatient admissions								
Acute admissions	35,177	37,022	-1,845	-5.0%	69,101	73,430	-4,329	-5.9%
Post-acute admissions	2,981	3,007	-26	-0.9%	5,933	5,853	80	1.4%
	38,158	40,029	-1,871	-4.7%	75,034	79,283	-4,249	-5.4%
Patient Days								
Acute patient days	184,216	191,780	-7,564	-3.9%	366,990	387,881	-20,891	-5.4%
Post-acute patient days	24,691	25,276	-585	-2.3%	49,396	49,687	-291	-0.6%
	208,907	217,056	-8,149	-3.8%	416,386	437,568	-21,182	-4.8%
Surgical cases								
Inpatient	14,009	14,415	-406	-2.8%	27,766	28,794	-1,028	-3.6%
Outpatient	34,981	34,580	401	1.2%	67,662	68,223	-561	-0.8%
	48,990	48,995	-5	0.0%	95,428	97,017	-1,589	-1.6%
ER visits	122,725	120,418	2,307	1.9%	233,951	235,483	-1,532	-0.7%
Observations	12,415	10,529	1,886	17.9%	24,567	20,568	3,999	19.4%
Clinic Outpatient Evaluation and Management Visits	764,591	733,572	31,019	4.2%	1,484,560	1,443,145	41,415	2.9%

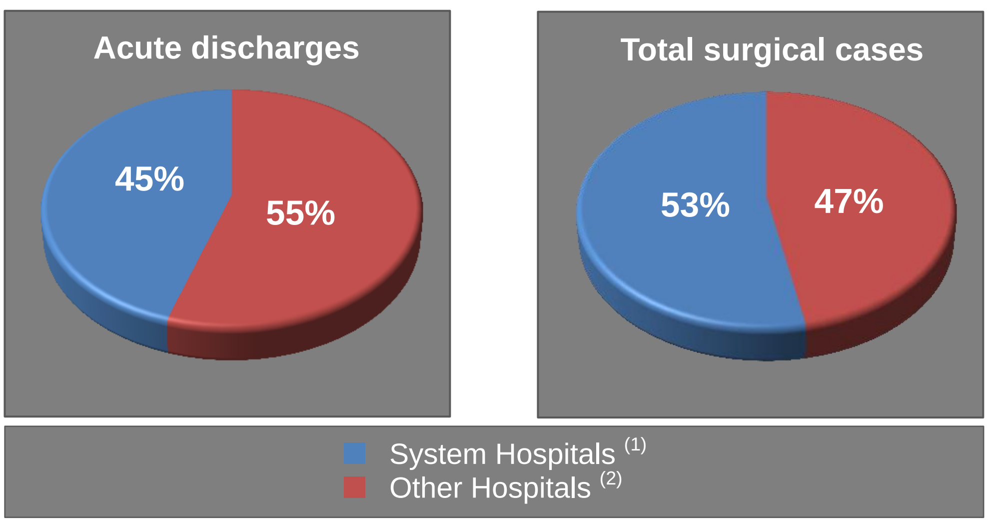
Inpatient admissions for the System decreased 5% in the second quarter and 6% in the first six months of 2014, compared to the same periods in 2013. However, outpatient observations for the System increased 18% in the second quarter and 19% in the first six months of 2014, compared to the same periods in 2013. On a combined basis, total inpatient admissions and outpatient observations were flat for the second quarter and for the first six months of 2014. The shift in patient volumes from admissions to observations is partially attributable to the implementation of the two midnight census rule by CMS in October 2013. Under this rule, surgical procedures, diagnostic tests and other treatments are generally classified as admissions if the hospital stay is expected to cross at least two midnights and if the physician admits the patient based upon that expectation.

The Clinic and Florida experienced decreases of 5% and 3%, respectively, in acute admissions in the first six months of 2014 compared to the same period in 2013. The community hospitals collectively experienced a 7% decrease in acute admissions, with year-over-year changes at individual hospitals ranging from -33% to +4%. According to data from the Center for Health Affairs, acute discharges in the Northeast Ohio service area decreased 5% in the first six months of 2014 compared to the same period in 2013.

Total surgical cases for the System were flat in the second quarter and decreased 2% in the first six months of 2014 compared to the same periods in 2013. The decrease in the first six months of 2014 was driven by a 1% decrease at the Clinic's main campus and family health centers and a 3% decrease at the community hospitals. Year-over-year changes at individual community hospitals ranged from -14% to +5%. According to data from the Center for Health Affairs, total surgical cases in northeast Ohio decreased 1% in the first six months of 2014 compared to the same period in 2013. The surgical mix of total surgical cases for the System for the first six months of 2014 was 29% inpatient and 71% outpatient, which represents a 1% shift in the surgical mix from inpatient to outpatient compared to the first six months of 2013.

Outpatient evaluation and management visits (E&M visits) at the Clinic's main campus and family health centers increased 4% in the second quarter and 3% for the first six months of 2014 compared to the same period in 2013. The continued growth in E&M visits was constrained by severe winter weather experienced across northeast Ohio during the first quarter of 2014, leading to many same-day cancellations.

The following charts summarize selected statistical information for Northeast Ohio hospitals for the six months ended June 30, 2014:



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 northeast Ohio reported by the Center for Health Affairs that are not included in System hospitals.

LIQUIDITY

Cash and Investments

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

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

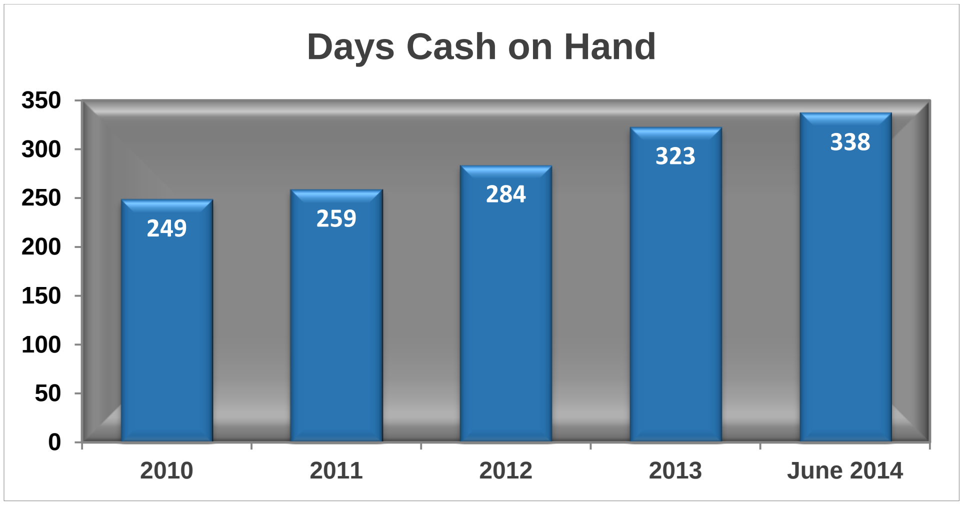
The following table sets forth the allocation of the System's cash and investments at June 30, 2014 and December 31, 2013:

Cash and Investments
(Dollars in thousands)

	June 30, 2014			December 31, 2013		
Cash and cash equivalents	$	357,621	6%	$	253,041	4%
Fixed income securities*		1,706,708	28%		1,638,662	28%
Marketable equity securities*		2,142,786	35%		2,055,242	35%
Alternative investments		1,911,912	31%		1,915,350	33%
Total cash and investments		6,119,027	100%		5,862,295	100%
Less restricted investments**		(700,348)			(734,144)	
Unrestricted cash and investments	$	5,418,679		$	5,128,151	
Days cash on hand		338			323	

* Fixed income securies 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 by captive insurance subsidiary 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 June 30, 2014:



At June 30, 2014, total cash and investments for the System (including restricted investments) were $6.119 billion, an increase of $257 million from $5.862 billion at December 31, 2013. Cash inflows consist of cash provided by operating activities and related investment income of $442 million and a net increase in restricted gifts and income of $40 million. Cash inflows were offset by net capital expenditures of $176 million and scheduled principal payments on debt of $49 million.

Included in the System's cash and investments are investments held by the System's captive insurance subsidiary. These investments totaled $157.5 million at June 30, 2014, with an asset mix of 16% cash and short-term investments, 51% fixed-income securities, 21% equity investments and 12% alternative investments. The asset mix reflects the need for liquidity within the captive 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 are $94.4 million of funds held by trustees. Funds held by trustees include $77.1 million of posted collateral. Collateral is comprised of $13.4 million related to a futures and options program within the System's investment portfolio and $63.7 million related to the System's interest rate swap contracts. The swap contracts require that collateral be posted when the market value of a contract in a liability position exceeds a certain threshold. The collateral is returned as the liability is reduced. The System also has $17.3 million of funds held by trustee for other purposes. Investment objectives of funds held by the trustees are designed to preserve principal by investing in highly liquid cash or fixed-income investments. At June 30, 2014, the asset mix of funds held by trustees was 22% cash and short-term investments and 78% fixed-income securities.

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

Alternative investments at June 30, 2014 and December 31, 2013 consist of the following:

Alternative Investments
(Dollars in thousands)

	June 30, 2014			December 31, 2013		
Hedge funds	$	1,243,934	65%	$	1,246,624	65%
Private equity/venture capital		402,626	21%		418,677	22%
Real estate		265,352	14%		250,049	13%
Total alternative investments	$	1,911,912	100%	$	1,915,350	100%

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

Investment Return

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

The System's long-term investment portfolio, which excludes assets held by the captive insurance subsidiary, reported investment gains of 3.1% for the second quarter of 2014, which is higher than the portfolio's benchmark of 3.0% and higher than investment losses of 0.7% experienced in the second quarter of 2013. For the first six months of 2014, the System experienced investment gains of 4.8%, which is higher than the portfolio's benchmark of 4.7% and higher than the investment gains of 3.1% experienced for the first six months of 2013.

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

Investment Return
(Dollars in thousands)

	For the quarter ended June 30		For the six months ended June 30	
	2014	2013	2014	2013
Other unrestricted revenue:				
Interest income and dividends	$ 391	$ 410	$ 729	$ 742
Nonoperating gains, net:				
Interest income and dividends	14,074	14,616	25,194	24,160
Net realized gains on sales of investments	43,613	63,278	110,948	107,721
Net change in unrealized gains (losses) on investments	91,854	(115,576)	72,349	(31,736)
Equity method income on alternative investments	30,695	27,091	43,886	56,071
Investment management fees	(4,051)	(3,212)	(7,833)	(6,213)
	176,185	(13,803)	244,544	150,003
Other changes in net assets:				
Net change in unrealized (losses) gains on nontrading investments	(7,152)	(432)	10,658	387
Investment income on restricted investments	9,328	934	12,632	9,350
Total investment return (loss)	$ 178,752	$ (12,891)	$ 268,563	$ 160,482

Pension Investments

In January 2014, the System updated its investment strategy and modified the allocation of pension plan investments in the CCHS Retirement Plan (Plan), the System's primary defined benefit pension plan. The Plan ceased benefit accruals for substantially all employees as of December 31, 2009, and ceased benefit accrual for remaining employees at various intervals through December 31, 2102. At December 31, 2013, the Plan had investments of $1.3 billion, which was 98% of the projected benefit obligation of the Plan. Coincident with the updated investment strategy the System reduced the asset allocation for common and preferred stocks by approximately 26% with a corresponding increase in cash and fixed income securities. The updated investment strategy was implemented because of the funded status of the Plan and the anticipation that such changes in investment strategy will result in lower volatility of future changes in funded status. Once the new investment strategy is fully implemented, it is anticipated that the duration of the investment assets will match the liabilities of the Plan over time. Additional revisions in asset allocations may occur based on future changes in the funded status of the Plan. As of June 30, 2014, the asset allocation of investments in the Plan was 4% cash and cash equivalents, 48% fixed-income investments, 29% equities, and 19% alternative investments.

Long-term Debt

At June 30, 2014, outstanding hospital revenue bonds for the System totaled $2.775 billion, comprised of $2.057 billion (74%) of fixed-rate bonds, $27 million (1%) of index-rate bonds and $691 million (25%) of variable-rate bonds. The System utilizes various interest rate swap derivative contracts to manage the risk of increased debt service resulting from rising market interest rates on variable-rate bonds and certain variable-rate operating lease payments. The total notional amount on the System's interest rate swap contracts at June 30, 2014 was $614 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 derivative contracts can be unwound by the System at any time, whereas the counterparty has the option to unwind the derivative contracts only upon an event of default as defined in the contracts.

Approximately $280 million of the variable-rate bonds are secured by irrevocable direct pay letters of credit or standby bond purchase agreements. Bonds supported by letters of credit or standby bond purchase agreements that expire within one year, require repayment of a remarketing draw within one year, or contain a subjective clause that, if declared by the lender, could cause immediate repayment of the bonds are classified as current liabilities.

The remaining $411 million variable-rate bonds are supported by the System's self-liquidity program. Bonds supported by self-liquidity include $99 million remarketed in daily mode and $312 million remarketed in commercial paper mode. Commercial paper bonds are structured with various term dates so that no more than $50 million of bonds mature within a five-day period. Bonds supported by self-liquidity are classified as current liabilities.

Combined current aggregate scheduled principal payments by calendar year, assuming the remarketing of the variable-rate bonds for the five years subsequent to December 31, 2013 are as follows (in millions): 2014 – $42.9; 2015 – $44.1; 2016 – $55.1; 2017 – $58.7; and 2018 – $60.9. The System has paid $41.0 million of scheduled principal payments in the first six months of 2014.

Glickman Tower
Cleveland, Ohio

Outstanding hospital revenue bonds for the System as of June 30, 2014 and December 31, 2013 consist of the following:

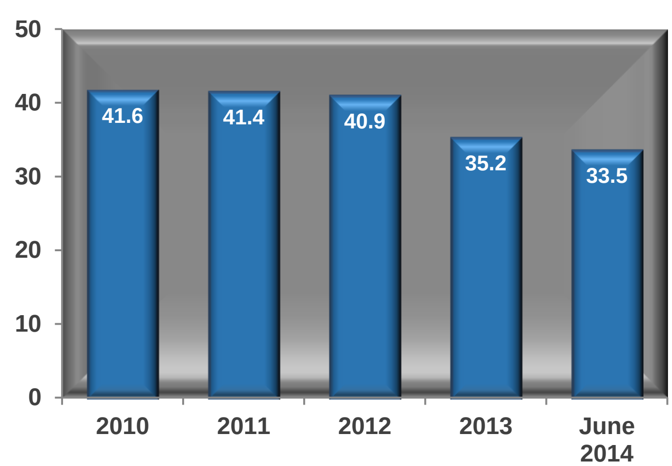
Hospital Revenue Bonds
(Dollars in thousands)

Series	Beneficiary	Type	Final Maturity	June 30 2014	December 31 2013
2013A	CCHS Obligated Group	Fixed / Index	2042	$ 89,380	$ 105,445
2013B	CCHS Obligated Group	Variable	2039	201,160	201,160
2013	Keep Memory Alive	Variable	2037	68,600	68,600
2012A	CCHS Obligated Group	Fixed	2039	469,485	469,485
2011A	CCHS Obligated Group	Fixed	2032	190,085	191,010
2011B	CCHS Obligated Group	Fixed	2031	33,270	35,190
2011C	CCHS Obligated Group	Fixed	2032	170,995	170,995
2009A	CCHS Obligated Group	Fixed	2039	305,400	305,400
2009B	CCHS Obligated Group	Fixed	2039	395,165	408,215
2008A	CCHS Obligated Group	Fixed	2043	429,500	438,395
2008B	CCHS Obligated Group	Variable	2043	369,250	369,250
2003C	CCHS Obligated Group	Variable	2035	41,905	41,905
2002	CCHS Obligated Group	Variable	2032	10,355	10,485
				$ 2,774,550	$ 2,815,535

The following charts summarize cash-to-debt and debt-to-capitalization ratios for the System at December 31 for the last four years and at June 30, 2014:

Cash to Debt %

Debt to Capitalization %



FINANCING DEVELOPMENTS

The Clinic is contemplating issuing additional debt (the "2014 Bonds") prior to the end of the current calendar year that may include (1) taxable fixed rate debt maturing up to 100 years after issuance, (2) taxable commercial paper notes or (3) tax-exempt fixed rate bonds maturing up to 40 years after issuance. The 2014 Bonds would be issued in an aggregate principal amount of approximately $500 million. The Clinic is not obligated to complete the planned issuance of the 2014 Bonds or any part thereof. Nothing contained herein should be construed as a solicitation of offers to purchase the 2014 Bonds.

BOND RATINGS

The obligated group's outstanding bonds have been assigned ratings of Aa2 (stable outlook) and AA- (positive outlook) by Moody's and S&P, respectively. In May 2013, Moody's affirmed their rating and outlook and S&P affirmed their rating and changed the outlook to positive from stable.

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

Bond Ratings

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

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

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

CONSOLIDATED RESULTS OF OPERATIONS

For the Quarters Ended June 30, 2014 and 2013

Operating income for the System in the second quarter of 2014 was $78.9 million, resulting in an operating margin of 4.8% as compared to operating income of $90.0 million and an operating margin of 5.5% in the second quarter of 2013. The lower operating income for the second quarter of 2014 primarily resulted from a 1.3% increase in total operating expenses, with notable increases experienced in pharmaceutical costs and salaries, wages and benefits. Patient volumes for the second quarter of 2014 were mixed, which contributed to a 0.5% increase in total operating revenues. Nonoperating gains for the System were $156.5 million in the second quarter of 2014 compared to nonoperating gains of $20.4 million in the second quarter of 2013. The increase from the prior year was primarily a result of gains and losses on investments attributable to overall changes in the financial markets offset by an unfavorable change in the fair value of the System's derivative contracts. Overall, the System reported an excess of revenues over expenses of $235.4 million in the second quarter of 2014 compared to an excess of revenues over expenses of $110.4 million in the second quarter of 2013.

The System's net patient service revenue increased $4.2 million (0.3%) in the second quarter of 2014, compared to the same period in 2013. The System experienced decreases in inpatient admissions of 4.7%. However, outpatient observations increased 17.9%, which resulted in combined admissions and observations to be relatively flat. Total surgical cases were flat, emergency department visits increased 1.9%, and outpatient E&M visits at the Clinic increased 4.2% in the second quarter of 2014 compared to the second quarter of 2013. Increases in revenue also resulted from rate increases on the System's managed care contracts and price increases that became effective in 2014. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts decreased $5.2 million (4.7%) in the second quarter of 2014, compared to the same period in 2013. Total uncompensated care, which includes provision for uncollectible accounts and charity care, decreased 18.6% over the same time period. The decrease is primarily attributable to the expansion of Medicaid eligibility in the state of Ohio, which has increased enrollment in the Medicaid program in 2014 and decreased the number of self-pay patients. Self-pay revenue for the System was 4.8% of total gross patient revenue in the second quarter of 2014, compared to 6.2% in the second quarter of 2013. Partially offsetting this shift is an increase in provision for uncollectible accounts resulting from high co-pay and deductible health plans. The growth in high deductible health plans is an industry trend that will likely continue to accelerate, particularly as patients enroll in the newly formed exchanges offered under the Affordable Care Act. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances continue to grow and are more difficult to collect than traditional insurance payors. Management continues to monitor the changing healthcare environment and resulting impact on the System and is focused on strategic initiatives that are designed to promote growth and increase value by improving quality and efficiency of care and managing costs throughout the System.

Other unrestricted revenues decreased $1.1 million (0.7%) in the second quarter of 2014, compared to the same period in 2013. The decrease was primarily due to a $5.8 million decrease in EHR incentive program revenue, a $3.0 million decrease in hotel revenue partially due to the closing of a hotel on the Clinic's main campus in August 2013 and a $2.5 million decrease in international contract revenue. These decreases were offset by a $6.2 million increase in outpatient pharmacy revenue and a $3.5 million increase in research grant revenue. The System also experienced a corresponding increase in expenses related to research activities.

Salaries and benefits increased $12.5 million (1.4%) in the second quarter of 2014, compared to the same period in 2013. Salaries, excluding benefits, increased $5.6 million (0.7%), due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2014. The System experienced a 2.7% decrease in average full-time equivalent employees in the second quarter of 2014, compared to the same period in 2013, primarily due to a voluntary retirement program offered to eligible employees in the fourth quarter of 2013. Employee benefit costs increased $6.9 million (5.2%). The System experienced an increase of $4.4 million in retirement benefits primarily due to an increase in defined contribution plan expenses and an increase of $3.0 million in employee and retiree healthcare costs.

Supply and pharmaceutical expenses increased $10.5 million (3.7%) in the second quarter of 2014, compared to the same period in 2013. Pharmaceutical costs increased $20.4 million primarily due to higher costs and increased utilization in the oncology departments and outpatient pharmacies. Increases in pharmaceutical costs also resulted from the acquisition of a specialized cancer center in the fourth quarter of 2013. Offsetting this increase was a $5.9 million decrease in implantables and other medical supplies and $4.0 million decrease in non-medical supplies. To address the challenge of rising supply and service costs in the healthcare industry, management is engaged in an organizational transformation program to identify and implement clinical and non-clinical savings initiatives through renegotiation, product standardization, utilization changes and improvements in procurement to payment processes. This ongoing program has returned over $200 million of annualized savings to the organization since its inception in 2010.

Purchased Services and other fees decreased $11.1 million (11%) in the second quarter of 2014, compared to the same period in 2013. In the second quarter of 2014, the System recorded a favorable adjustment to contingent liabilities of $8.4 million that had been accrued in prior years and are now resolved. In addition, the System experienced a $1.9 million decrease in state franchise fee expenses. The state franchise fee is an assessment implemented by the State of Ohio in 2009 that is charged to hospitals based on a percentage of costs and is used to fund the State Medicaid program.

Administrative services increased $2.7 million (6.7%) in the second quarter of 2014, compared to the same period in 2013. The increase was primarily due to an increase in expenses related to research activities of $4.1 million, which was offset by a reduction in expenses related to employee travel and professional dues and licenses of $1.0 million.

Insurance expense increased $3.7 million (23.9%) in the second quarter of 2014, compared to the same period in 2013. The increase is primarily due to a $3.1 million increase in professional malpractice expense. The System utilizes an independent actuarial firm to review loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last few years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs. These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense decreased $0.7 million (2.6%) in the second quarter of 2014, compared to the same period in 2013. The System issued $306.6 million of hospital revenue bonds in the second quarter of 2013 that were partially used to refund $284.9 million of existing hospital revenue bonds. The new bonds were issued at a lower interest rate than the previously refunded bonds. The System also redeemed $7.9 million of the Lakewood Hospital Association Series 2003 Bonds in the fourth quarter of 2013, which further reduced interest expense on hospital revenue bonds. In addition to these bond transactions, the System reduced its total principal amount of outstanding bonds by $41.0 million in the first six months of 2014 through payment of regularly scheduled principal payments.

Depreciation and amortization expenses increased $2.1 million (2.2%) in the second quarter of 2014, compared to the same period in 2013. Changes in depreciation include property, plant and equipment that was fully depreciated in 2013 offset by depreciation for property, plant and equipment that was acquired and placed into service in 2013 and 2014.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $156.6 million in the second quarter of 2014 compared to $20.4 million in the second quarter of 2013. The net increase of $136.2 million resulted primarily from a $190.0 million favorable variance in net investment gains and losses on the System's investment portfolio offset by a $53.9 million unfavorable variance in derivative gains and losses. Derivative gains and losses result from changes in the interest rate benchmark associated with the System's interest rate swap contracts and include net interest paid or received under the swap agreements. The System's long-term investment portfolio reported investment gains of 3.1% for the second quarter of 2014, which is higher than the portfolio's benchmark of 3.0% and higher than investment losses of 0.7% experienced in the second quarter of 2013. Investment return also benefited from the growth in the investment portfolio in 2014.

For the Six Months Ended June 30, 2014 and 2013

Operating income for the System in the first six months of 2014 was $120.7 million, resulting in an operating margin of 3.7% as compared to operating income of $168.6 million and an operating margin of 5.2% in the first six months of 2013. The lower operating income for the first six months of 2014 primarily resulted from lower inpatient admissions and surgical cases, which contributed to a 0.1% decrease in operating revenues. Total operating expenses increased 1.5%, with notable increases in pharmaceutical costs and salaries, wages, and benefits.

Nonoperating gains for the System were $201.6 million in the first six months of 2014 compared to nonoperating gains of $195.7 million in the first six months of 2013. The increase from the prior year was primarily a result of gains and losses on investments attributable to overall changes in the financial markets offset by an unfavorable change in the fair value of the System's derivative contracts. Overall, the System reported an excess of revenues over expenses of $322.3 million in the first six months of 2014 compared to an excess of revenues over expenses of $364.3 million in the first six months of 2013.

The System's net patient service revenue increased $2.0 million (0.1%) in the first six months of 2014, compared to the same period in 2013. The System experienced decreases in inpatient admissions of 5.4%. However, outpatient observations increased 19.4%, which resulted in combined admissions and observations to be relatively flat. Total surgical cases decreased 1.6%, emergency department visits decreased 0.7% and outpatient E&M visits at the Clinic increased 2.9% in the first six months of 2014 compared to the first six months of 2013. Additionally, acute case mix for the System in the first six months of 2014 was 1.6% higher than the first six months of 2013, which has resulted in more inpatient revenue per patient. Increases in revenue also resulted from rate increases on the System's managed care contracts and price increases that became effective in 2014. Over the last few years, the System has initiated national, regional and local revenue management projects designed to improve patient care access throughout the System.

Provision for uncollectible accounts decreased $4.6 million (2.1%) in the first six months of 2014, compared to the same period in 2013. Total uncompensated care, which includes provision for uncollectible accounts and charity care, decreased 17.0% over the same time period. The decrease is primarily attributable to the expansion of Medicaid eligibility in the State of Ohio, which has increased enrollment in the Medicaid program in 2014 and has resulted in a decrease in the number of self-pay patients. Self-pay revenue for the System was 5.5% of total gross patient revenue in the first six months of 2014, compared to 6.2% in the first six months of 2013. Partially offsetting this shift is an increase in provision for uncollectible accounts resulting from high co-pay and deductible health plans. The growth in high deductible health plans is an industry trend that will likely continue to accelerate, particularly as patients enroll in the newly formed exchanges offered under the Affordable Care Act. Employers have also shifted a greater portion of the cost of care to employees to manage health benefit costs resulting in rising patient responsibility balances. These balances continue to grow and are more difficult to collect than traditional insurance payors. Management continues to monitor the changing healthcare environment and resulting impact on the System and is focused on strategic initiatives that are designed to promote growth and increase value by improving quality and efficiency of care and managing costs throughout the System.

Other unrestricted revenues decreased $9.1 million (3.1%) in the first six months of 2014, compared to the same period in 2013. The decrease was primarily due to a $12.0 million decrease in EHR incentive program revenue, a $6.4 million decrease in gifts and assets released from restriction primarily due to a reduction in pledge payments received and a $4.1 million decrease in hotel revenue partially due to the closing of a hotel on the Clinic's main campus in August 2013. These decreases were offset by an $11.8 million increase in outpatient pharmacy revenue.

Salaries and benefits increased $35.9 million (2.0%) in the first six months of 2014, compared to the same period in 2013. Salaries, excluding benefits, increased $23.3 million (1.5%), due to annual salary adjustments averaging 2-3% across the System that were awarded in the second quarter of 2014. The System experienced a 1.8% decrease in average full-time equivalent employees in the first six months of 2014, compared to the same period in 2013, primarily due to a voluntary retirement program offered to eligible employees in the fourth quarter of 2013. Employee benefit costs increased $12.5 million (4.5%). The System experienced an increase of $7.2 million in retirement benefits primarily due to an increase in defined contribution plan expenses, an increase of $4.8 million in employee and retiree healthcare costs and a $1.9 million increase in FICA expenses, which is attributable to the increase in salaries.

Supply and pharmaceutical expenses increased $11.1 million (2.0%) in the first six months of 2014, compared to the same period in 2013. Pharmaceutical costs increased $31.0 million primarily due to higher costs and increased utilization in the oncology departments and outpatient pharmacies. Increases in pharmaceutical costs also resulted from the acquisition of a specialized cancer center in the fourth quarter of 2013. Offsetting this increase was a $12.5 million decrease in implantables and other medical supplies primarily due to the reduction in inpatient admissions and surgical cases and a $7.4 million decrease in non-medical supplies. To address the challenge of rising supply and service costs in the healthcare industry, management is engaged in an organizational transformation program to identify and implement clinical and non-clinical savings initiatives through renegotiation, product standardization, utilization changes and improvements in procurement to payment processes. This ongoing program has returned over $200 million of annualized savings to the organization since its inception in 2010.

Purchased services and other fees decreased $9.8 million (5.2%) in the first six months of 2014, compared to the same period in 2013. In the second quarter of 2014, the System recorded a favorable adjustment to contingent liabilities of $8.4 million that had been accrued in prior years and are now resolved. In addition, the System experienced a $1.3 million decrease in state franchise fee expenses.

Administrative services increased $4.4 million (5.7%) in the first six months of 2014, compared to the same period in 2013. The increase is primarily due to an increase in expenses related to research activities of $5.8 million and an increase in consulting fees and other professional services of $2.3 million. The System has various strategic initiatives directed at reducing costs. These increases were offset by a decrease in expenses related to employee travel and professional dues and licenses of $3.0 million.

Facilities expenses decreased $1.1 million (0.7%) in the first six months of 2014, compared to the same period in 2013, primarily due to a $1.7 million decrease in rent and lease expenses.

Insurance expense increased $4.2 million (13.7%) in the first six months of 2014, compared to the same period in 2013. The increase is primarily due to a $3.7 million increase in professional malpractice expense. The System utilizes an independent actuarial firm to review loss experience and establish estimated funding levels to the System's captive insurance subsidiary. Over the last few years, the System has undertaken numerous initiatives to manage its medical malpractice insurance expense that resulted in reducing the number of claims and lawsuits and associated costs.

These initiatives include hiring additional staff devoted to clinical risk management, promoting patient safety to prevent untoward events, and expanding education programs geared to enhance quality throughout the organization. The System has also taken, where appropriate, a more proactive approach to expedite the settlement of claims, which has reduced claim expenses and has resulted in more favorable settlements.

Interest expense decreased $1.2 million (2.2%) in the first six months of 2014, compared to the same period in 2013. The System issued $306.6 million of hospital revenue bonds in the second quarter of 2013 that were partially used to refund $284.9 million of existing hospital revenue bonds. The new bonds were issued at a lower interest rate than the previously refunded bonds. The System also redeemed $7.9 million of the Lakewood Hospital Association Series 2003 Bonds in the fourth quarter of 2013, which further reduced interest expense on hospital revenue bonds. In addition to these bond transactions, the System reduced its total principal amount of outstanding bonds by $41.0 million in the first six months of 2014 through payment of regularly scheduled principal payments.

Depreciation and amortization expenses increased $1.9 million (1.0%) in the first six months of 2014, compared to the same period in 2013. Changes in depreciation include property, plant and equipment that was fully depreciated in 2013 offset by depreciation for property, plant and equipment that was acquired and placed into service in 2013 and 2014.

Gains and losses from nonoperating activities are recorded below operating income in the statement of operations. These items resulted in a net gain to the System of $201.6 million in the first six months of 2014 compared to $195.7 million in the first six months of 2013. The net increase of $5.9 million resulted primarily from a $94.5 million favorable variance in net investment gains and losses on the System's investment portfolio offset by a $88.7 million unfavorable variance in derivative gains and losses. Derivative gains and losses result from changes in the interest rate benchmark associated with the System's interest rate swap contracts and include net interest paid or received under the swap agreements. The System's long-term investment portfolio reported investment gains of 4.8% for the first six months of 2014, which is higher than the portfolio's benchmark of 4.7% and higher than investment gains of 3.1% experienced in the first six months of 2013. Investment return also benefited from the growth in the investment portfolio in 2014.

BALANCE SHEET – JUNE 30, 2014 COMPARED TO DECEMBER 31, 2013

Patient accounts receivable, net of allowances for uncollectible accounts, increased $77.7 million (10.0%) from December 31, 2013 to June 30, 2014. The System has experienced a growth in accounts receivable from insurance payors, including Medicare, Medicaid and other managed care and commercial payors, as well as an increase in patient responsibility accounts receivable. Patient responsibility accounts, which represents the portion of services that is not paid by a patient's insurance company, have increased as a result of employers shifting a greater portion of the cost of care to employees, typically in the form of co-pays and deductibles. These balances have continued to grow and are generally more difficult to collect than traditional insurance payors. Accounts receivable from Medicaid has grown due to expansion of Medicaid eligibility in the state of Ohio, which has increased enrollment in the Medicaid program in 2014 and created a backlog of Medicaid applications at many county offices. Prior to Medicaid eligibility expansion, many of these patients would have qualified for free or discounted care under the System's financial assistance policies. The System records estimated allowances that result in patient accounts receivable being reported at the net amount expected to be received. Days revenue outstanding for the System increased from 48 days at December 31, 2013 to 52 days at June 30, 2014.

Investments for current use, which is comprised of bond trustee funds and assets held by the captive insurance subsidiary, decreased $91.8 million (66.0%) from December 31, 2013 to June 30, 2014. Current bond trustee funds decreased $91.8 million due to the timing of principal and interest payments due in early 2014 that were funded to the bond trustee in December 2013. Assets held by the captive insurance subsidiary reported in investments for current use represents investments that will be used to pay the current portion of estimated claim liabilities. There was no change in these investments in the first six months of 2014.

Other current assets decreased $19.6 million (6.6%) from December 31, 2013 to June 30, 2014. The decrease in other current assets was primarily due to a $44.2 million decrease in third-party receivables, which are comprised of receivables related to Medicaid Upper Payment Limit, Hospital Care Assurance Program and EHR incentives, and a $7.0 million decrease in receivables related to research activities. Offsetting these decreases was an $18.7 million increase in prepaid expenses, a $9.7 million increase in current pledge receivables and an $8.0 million increase in international contract receivables.

Unrestricted investments increased $277.8 million (5.5%) from December 31, 2013 to June 30, 2014. Increases in unrestricted investments include positive cash flow from operations and positive earnings on investments. The increases were offset by capital expenditures of $175.9 million.

Funds held by trustees increased $23.7 million (33.6%) from December 31, 2013 to June 30, 2014. The increase was primarily due to $21.8 million of additional collateral posted with the counterparties on the System's derivative contracts and $5.5 million of additional collateral to support a futures and options program within the System's investment portfolio. Offsetting these increases is a $3.5 million decrease in other trusteed funds related to certain System contracts.

Assets held by the System's captive insurance subsidiary increased $14.5 million (15.2%) from December 31, 2013 to June 30, 2014. The increase in the captive insurance assets is primarily related to insurance premiums received by the captive in excess of reimbursement payments for claims previously settled and paid by other System entities and positive market returns in the captive's investment portfolio.

Donor restricted assets increased $19.8 million (4.6%) from December 31, 2013 to June 30, 2014. The increase in donor restricted assets was primarily from investment gains on restricted investments and receipt of donor restricted gifts in excess of expenditures from restricted funds.

Net property, plant and equipment decreased $18.4 million (0.5%) from December 31, 2013 to June 30, 2014. In the first six months of 2014, the System had expenditures for property, plant and equipment of $175.9 million offset by depreciation expense of $192.8 million. Capital expenditures in 2014 include amounts paid on retainage liabilities recorded at December 31, 2013, which decreased $8.0 million in the first six months of 2014. Expenditures for property, plant and equipment were incurred at numerous facilities across the System and include expenditures for strategic construction, expansion and technological investment as well as replacement of existing facilities and equipment. For a complete description of many of System's current projects, refer to "EXPANSION AND IMPROVEMENT PROJECTS."

Other noncurrent assets increased $27.4 million (5.8%) from December 31, 2013 to June 30, 2014. The increase was primarily due to an increase in pledges receivable of $14.2 million and an increase in trusts and interests in community foundations of $3.9 million.

Accounts payable decreased $55.0 million (16.9%) from December 31, 2013 to June 30, 2014. The decrease was principally attributable to the timing of payment processing, including retainage liabilities associated with the System's construction projects, and a $20.0 million reduction in outstanding checks at certain financial institutions.

Compensation and amounts withheld from payroll increased $38.2 million (14.9%) from December 31, 2013 to June 30, 2014. The change was primarily attributable to the timing of payroll and growth in employee benefit accruals.

Other current liabilities decreased $26.0 million (6.8%) from December 31, 2013 to June 30, 2014. The decrease was primarily due to a $27.8 million decrease in state franchise fee liabilities due to the timing of payments for this program and a $10.7 million decrease in international contract deferred revenue. These decreases were offset by a $3.2 million increase in accrued employee healthcare benefits and a $3.1 million increase in deferred revenue related to research activities.

Hospital revenue bonds decreased $43.3 million (1.8%) from December 31, 2013 to June 30, 2014. The decrease is due to reclassifications of scheduled principal payments from long-term to current.

Professional and general insurance liability reserves increased $12.4 million (9.3%) from December 31, 2013 to June 30, 2014. The increase is due to the growth in expected claim liabilities in excess of claim payments.

Accrued retirement benefits decreased $11.3 million (4.3%) from December 31, 2013 to June 30, 2014. The System froze its primary defined benefit pension plan for substantially all employees in 2009, with benefits for remaining participants ceasing at various intervals through December 31, 2012. The decrease is primarily due to the recognition of negative net periodic benefit cost on the frozen pension plan, which has resulted from actuarial expected return on plan investments in excess of interest cost incurred on plan obligations.

Other noncurrent liabilities increased $25.7 million (6.2%) from December 31, 2013 to June 30, 2014. The increase is primarily due to an increase of $30.1 million in derivative liabilities associated with changes in the fair value of the System's interest rate swap contracts.

Total net assets increased $383.4 million (6.2%) from December 31, 2013 to June 30, 2014. Unrestricted net assets increased $334.3 million (6.1%), comprised primarily of an excess of revenues over expenses of $322.3 million, unrealized gains on available-for-sale investments of $10.7 million and assets released from restriction for capital purposes of $3.0 million, offset by retirement benefit adjustments of $1.5 million related to amortization of prior service credits on pension and postretirement benefit plans. Temporarily restricted net assets increased $41.9 million (9.1%), primarily due to $46.8 million in temporarily restricted gifts and $12.6 million in restricted investment income, offset by $18.1 million in assets released from restrictions.

Permanently restricted net assets increased $7.2 million (2.7%) primarily due to $5.8 million of permanently restricted gifts and an increase of $1.4 million in the value of the System's perpetual trusts.

Cleveland Clinic
Circa 1921

FORWARD-LOOKING STATEMENTS

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

- Changes to the Medicare and Medicaid reimbursement systems resulting in reductions in payments, and/or changes in eligibility of patients to qualify for Medicare and Medicaid;
- Legislative reforms or actions that reduce the payment for, and/or utilization of, healthcare services, such as the Patient Protection and Affordable Care Act, which was passed into law in 2010, and/or draft legislation to address reimbursement cuts related to the Sustainable Growth Rate Formulas;
- Adjustments resulting from Medicare and Medicaid reimbursement audits, including audits initiated by the Medicare Recovery Audit Contractor program;
- Increased competition in the areas served by the System;
- The ability of the System to access capital for the funding of capital projects;
- Availability of malpractice insurance at reasonable rates, if at all;
- The System's ability to recruit and retain professionals;
- General economic and business conditions, internationally, nationally and regionally, including the impact of financial market conditions and volatility and increases in the number of self-pay patients;
- The declining population in the Greater Cleveland area;
- Impact of federal laws on tax-exempt organizations and state law relating to exemption from income taxes, sales taxes and real estate taxes;
- Management, utilization and increases in the cost of medical drugs and devices as technological advancement progresses without concurrent increases in federal reimbursement;
- Ability of the System to adjust its cost structure and reduce operating expenses; and
- Changes in accounting standards or practices.

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