Audited Consolidated Financial Statements, Reports, Supplementary Information, and Schedule Required by the Uniform Guidance

Cedars-Sinai Health System
Year Ended June 30, 2018
With Report of Independent Auditors

Ernst & Young LLP

Building a better working world

Cedars-Sinai Health System

Audited Consolidated Financial Statements, Reports,
Supplementary Information, and Schedule Required by the Uniform Guidance

Year Ended June 30, 2018

Contents

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Report of Independent Auditors

Management and the Board of Directors
Cedars-Sinai Health System

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Cedars-Sinai Health System, which comprise the consolidated balance sheet as of June 30, 2018, and the related consolidated statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Cedars-Sinai Health System at June 30, 2018, and the consolidated results of its operations and changes in net assets, and its cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The Schedule of Expenditures of Federal Awards as required by Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our report dated October 29, 2018, on our consideration of Cedars-Sinai Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Cedars-Sinai Health System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Cedars-Sinai Health System's internal control over financial reporting and compliance.

Ernst & Young LLP

October 29, 2018

Cedars-Sinai Health System

Consolidated Balance Sheet

(Dollar Amounts Expressed in Thousands)

June 30, 2018

Assets		
Current assets:		
Cash and cash equivalents	$	411,322
Short-term investments		1,255,144
Board-designated assets		1,087,653
Current portion of assets limited as to use:		
Funds held by trustee		397
Pledge receivable		33,015
Managed care reserve fund		78,867
Patient accounts receivable, less allowance for uncollectible accounts of $134,028		626,508
Due from third-party payers		5,069
Inventory		46,754
Prepaid expenses and other assets		233,156
Total current assets		3,777,885
Assets limited as to use:		
Investments		547,585
Pledge receivable, less current portion		192,781
Funds held by trustee		382
		740,748
Property and equipment, net		3,036,489
Other assets		432,755
Total assets	$	7,987,877

Cedars-Sinai Health System

Consolidated Balance Sheet (continued)

(Dollar Amounts Expressed in Thousands)

June 30, 2018

Liabilities and net assets	
Current liabilities:	
Accounts payable and other accrued liabilities	$ 467,218
Accrued payroll and related liabilities	357,447
Risk pool liabilities	114,750
Current maturities of long-term debt	50,783
Total current liabilities	990,198
Long-term debt, less current maturities	1,507,146
Accrued workers' compensation and malpractice insurance claims, less current portion	150,962
Pension liability	59,170
Other liabilities	95,011
Net assets:	
Unrestricted:	
Controlling interests	4,320,002
Non-controlling interests	58,791
Temporarily restricted	478,149
Permanently restricted	328,448
Total net assets	5,185,390
Total liabilities and net assets	$ 7,987,877

See accompanying notes.

Cedars-Sinai Health System

Consolidated Statement of Operations and Changes in Net Assets

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

Unrestricted net assets activity	
Unrestricted revenues, gains, and other support:	
Patient service revenue (net of contractual allowances and discounts)	$ 3,739,817
Provision for bad debts	(37,352)
Net patient service revenue less provision for bad debts (before Medi-Cal Fee Program)	3,702,465
Medi-Cal Fee Program revenue	183,228
Net patient service revenue	3,885,693
Premium revenues	168,236
Other operating revenues	113,499
Net assets released from restrictions	198,434
Total unrestricted revenues, gains, and other support	4,365,862
Expenses:	
Salaries and related costs	2,073,133
Professional fees	286,387
Materials, supplies, and other	1,333,224
Medi-Cal Fee Program expense	191,273
Interest	40,643
Depreciation and amortization	212,064
Total expenses	4,136,724
Income from operations	229,138
Investment gain	110,620
Gain from investment in joint ventures	8,001
Excess of revenues over expenses before inherent contribution from affiliation	347,759
Inherent contribution from affiliation	508,088
Excess of revenues over expenses	855,847
Less excess of revenues over expenses attributable to non-controlling interests	(2,938)
Excess of revenues over expenses attributable to the Health System	$ 852,909

Consolidated Statement of Operations and Changes in Net Assets (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

Unrestricted net assets activity (continued)	
Unrestricted controlling net assets activity:	
Excess of revenues over expenses attributable to the Health System	$ 852,909
Net assets released from restriction related to property and equipment	4,452
Change in pension liability	51,405
Increase in unrestricted net assets attributable to the Health System	908,766
Unrestricted non-controlling net assets activity:	
Non-controlling interests from acquisitions	4,122
Excess of revenues over expenses attributable to non-controlling interests	2,938
Distributions to non-controlling interests	(2,289)
Increase in unrestricted net assets attributable to non-controlling interests	4,771
Increase in unrestricted net assets	913,537
Temporarily restricted net assets activity	
Inherent contribution from affiliation	114,107
Contributions, grants and other	211,246
Investment income	12,206
Net assets released from restrictions	(202,886)
Increase in temporarily restricted net assets	134,673
Permanently restricted net assets activity	
Inherent contribution from affiliation	3,313
Contributions and other	15,815
Increase in permanently restricted net assets	19,128
Increase in net assets	1,067,338
Net assets at beginning of year	4,118,052
Net assets at end of year	$ 5,185,390

See accompanying notes.

Cedars-Sinai Health System

Consolidated Statement of Cash Flows

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

Operating activities	
Increase in net assets	$ 1,067,338
Adjustments to reconcile increase in net assets to net cash provided by operating activities:	
Inherent contribution from affiliation	(571,658)
Depreciation and amortization	212,064
Amortization of deferred financing costs and bond premiums	(12,061)
Provision for bad debts	37,352
Restricted contributions	(20,687)
Non-controlling interests from acquisitions	(4,122)
Unrealized losses on investments	18,736
Changes in operating assets and liabilities:	
Patient accounts receivable	14,269
Due from third-party payers	5,302
Inventory, prepaid expenses, and other current assets	(70,091)
Assets limited as to use, net of assets held by bond trustee	(4,773)
Accounts payable and other accrued liabilities	68,527
Accrued payroll and related liabilities	14,603
Risk pool liabilities	(2,113)
Other long-term liabilities	(62,826)
Net cash provided by operating activities before net purchases of trading investments	689,860
Net purchases of trading investments	(390,174)
Net cash provided by operating activities	299,686
Investing activities	
Expenditures for property and equipment	(285,313)
Purchase consideration for acquisitions	(4,693)
Decrease in assets held by bond trustee	120,372
Increase in other assets	(9,871)
Sales of alternative investments	51,289
Purchases of alternative investments	(29,947)
Net cash used in investing activities	(158,163)

Cedars-Sinai Health System

Consolidated Statement of Cash Flows (continued)

(Dollar Amounts Expressed in Thousands)

Year Ended June 30, 2018

Financing activities		
Principal payments on long-term debt	$	(30,523)
Restricted contributions		20,687
Net cash used in financing activities		(9,836)
Increase in cash and cash equivalents		131,687
Cash and cash equivalents – beginning of year		279,635
Cash and cash equivalents – end of year	$	411,322
Supplemental cash flow information		
Interest paid	$	60,185

The Health System capitalized property and equipment of approximately $42,839 at June 30, 2018 that had not been paid. The offsetting amount due was recorded on the consolidated balance sheet under accounts payable and other accrued liabilities.

See accompanying notes.

1. Organization

Cedars-Sinai Health System, a California nonprofit, public benefit corporation (the Health System), is tax-exempt under the provisions of the Internal Revenue Code (the Code) and applicable provisions of the Franchise Tax Code of the state of California. Cedars-Sinai Health System was created and incorporated in May 2017 as the parent organization to facilitate an affiliation between Cedars-Sinai Medical Center and Torrance Health Association, Inc. Effective May 1, 2017, the Health System is the sole corporate member of Cedars-Sinai Medical Center and its affiliates. Effective February 1, 2018, the Health System became the sole corporate member of Torrance Health Association, Inc. and its affiliates. The accompanying consolidated financial statements include the accounts of the Health System and its affiliate or subsidiary organizations as detailed below:

Cedars-Sinai – The accompanying consolidated financial statements include the accounts of Cedars-Sinai Medical Center and its affiliates, collectively referred to as Cedars-Sinai, as of and for the year ended June 30, 2018. The following entities are included in the accompanying consolidated financial statements:

> Cedars-Sinai Medical Center (CSMC) is a California nonprofit, public benefit corporation that owns and operates a hospital with 886 licensed beds in Los Angeles, California, and provides patient care, medical research, health education, and community service. Cedars-Sinai Medical Center is the sole corporate member of Cedars-Sinai Medical Care Foundation and Marina Del Rey Hospital.
>
> Cedars-Sinai Medical Care Foundation (CSMCF) is a California nonprofit, public benefit corporation that operates, manages, and maintains a multi-specialty clinic, holds payer contracts and the assets of acquired physician and physician group practices and independent practice associations; and contracts for physician services pursuant to professional services agreements.
>
> CFHS Holdings, Inc. (dba Marina Del Rey Hospital) is a California nonprofit public benefit corporation, which owns and operates Marina Del Rey Hospital, a community hospital with 145 licensed beds.

1. Organization (continued)

Torrance Memorial – The accompanying consolidated financial statements include the accounts of Torrance Health Association, Inc. and its affiliates, collectively referred to as Torrance Memorial, as of and for the five-month period ended June 30, 2018. The following entities are included in the accompanying consolidated financial statements:

> Torrance Health Association, Inc. (THA) is a California nonprofit, public benefit corporation and is the parent organization for the entities listed below. THA was formed to engage in various health care related activities. THA is the sole corporate member of Torrance Memorial Medical Center and Torrance Memorial Medical Center Health Care Foundation.
>
> Torrance Memorial Medical Center (TMMC) is a California nonprofit corporation and is licensed as a 649-bed general acute care hospital that provides inpatient, outpatient, and emergency care services for residents in the surrounding South Bay community.
>
> Torrance Memorial Medical Center Health Care Foundation (TMMCF) is a California nonprofit corporation organized to raise funds for the support of TMMC.

2. Summary of Significant Accounting Policies

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States (U.S. GAAP) 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 revenues and expenses during the reporting period. Significant items subject to such estimates include the carrying amounts for goodwill and property and equipment, valuation of deferred gifts, purchase accounting for acquisitions, valuation allowances for receivables, liabilities for medical claims incurred but not reported, third-party payables and receivables, risk pool liabilities, pension, and self-insured programs. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies (continued)

Net Patient Service Revenues

The Health System has agreements with third-party payers that provide for payments to the Health System at amounts different from established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers.

The Health System is reimbursed for services provided to patients under certain programs administered by governmental agencies. Laws and regulations governing the Medicare and Medi-Cal programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medi-Cal programs. The Health System believes it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that may have a material impact on the accompanying consolidated financial statements.

Net patient service revenue by major payer source is as follows for the year ended June 30, 2018:

Medicare	$ 907,748
Medi-Cal	252,096
Commercial and Managed Care	2,553,707
Self-pay and other	209,494
Patient service revenue, net of contractual allowances and discounts	3,923,045
Provision for bad debts	(37,352)
Net patient service revenues	$ 3,885,693

The administrative procedures related to the cost reimbursement programs in effect generally preclude final determination of amounts due until cost reports are audited or otherwise reviewed and settled upon with the applicable administrative agencies. Estimation differences between final settlements and amounts accrued in previous years are reported as adjustments of the current year's net patient service revenue. In the opinion of management, adequate provision has been made for

2. Summary of Significant Accounting Policies (continued)

adjustments, if any, that might result from subsequent review. The Health System recorded revenues from the California Hospital Fee Program under net patient service revenues from Medi-Cal, as further described below.

Medi-Cal Fee Program

As part of the American Recovery and Reinvestment Act economic stimulus package passed in 2009, Congress temporarily increased the Federal Medical Assistance Percentage (FMAP) for all states, allowing states to draw down increased federal dollars for hospitals that provide medical care for Medicaid patients. California hospitals organized to pursue this stimulus funding through the California Hospital Fee Programs (the Programs). Passed into law by the California state government and approved by the Centers for Medicare and Medicaid Services (CMS) in fiscal 2012, the Programs provide enhanced revenues related to provision of services to Medicaid patients, offset to a degree by the requirement to pay a fee (known as the Quality Assurance (QA) Fee) based on established rates applied to each hospital's historical patient days.

Prior to 2017, the timing of revenue and expense recognition of the Programs was based on the timing of CMS approval which did not consistently match the timing of the various Programs due to delays in approval. With the passage of time, and the administration of the Programs, it has been determined that there is persuasive evidence of an arrangement in existence despite whether CMS has finalized the actual amounts paid. Accordingly, during the year ended June 30, 2018, the Health System determined that the supplemental payments met all criteria related to revenue recognition and the QA Fees are both probable and estimable for the 30-month Program covering the period from January 1, 2017 through June 30, 2019. Accordingly, all related supplemental payments have been recognized as net patient service revenue, and related QA Fees have been recognized as Medi-Cal Fee Program expense in the year ended June 30, 2018.

Total QA Fees incurred by the Health System were $191,273 during fiscal 2018, while revenue from the Program totaled $183,228 during fiscal 2018. In connection with the Program, the Health System applied for a grant from the California Health Foundation & Trust related to future shortfalls from the Program. The Health System recorded $4,883 for this grant during fiscal 2018.

2. Summary of Significant Accounting Policies (continued)

Premium Revenues and Related Costs

The Health System has agreements with various health maintenance organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, monthly capitation payments are received based on the number of each HMO's participants, regardless of services actually performed. These agreements also contain risk-sharing provisions with medical groups whereby additional amounts may be due or paid. In addition, the HMOs make fee-for-service payments for non-capitated services based upon discounted fee schedules. Such payments received are recorded as premium revenues.

The costs of health services provided by other health care providers to the participants, including administrative costs and out-of-area or emergency services, are included in professional fees, and totaled approximately $61,835 for the year ended June 30, 2018. Such costs are accrued in the period in which the services are provided based in part on estimates, including an accrual for services provided by others, but not reported to Cedars-Sinai Medical Care Foundation and Torrance Health Association, Inc.

Provision for Uncollectible Accounts

Patient service revenue, net of contractual allowances and discounts, is reduced by the provision for bad debts, and accounts receivable is reduced by an allowance for uncollectible accounts. The Health System establishes an allowance for uncollectible accounts based on many factors, including payer mix, age of receivables, historical cash collection experience, and other relevant information. A significant portion of the Health System's uninsured patients will be unable or unwilling to pay for services provided, and a significant portion of the Health System's insured patients will be unable or unwilling to pay for co-payments and deductibles. Thus, the Health System records a provision for bad debts related to these insured and uninsured patients in the period the services are provided. The Health System writes down the expected reimbursement after reasonable collection efforts have been exhausted.

2. Summary of Significant Accounting Policies (continued)

Charity Care

The Health System provides charity care to patients who meet certain criteria under its financial assistance policy. This policy defines charity care as uncompensated services provided to patients who are deemed indigent and to patients who are uninsured. During the year ended June 30, 2018, the Health System incurred $27,231 in costs to provide charity care, respectively, which is calculated based on a ratio of cost to gross charges.

Excess of Revenues Over Expenses

The consolidated statement of operations and changes in net assets includes the excess of revenues over expenses, which is considered the performance indicator. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses, include contributions of long-lived assets (including assets acquired using contributions which, by donor restrictions, were to be used for the purposes of acquiring such assets) and changes in benefit plan liabilities.

Inventory

Inventory is stated at cost (using the first-in, first-out method), which is not in excess of market value.

Assets Held for Future Use

The Health System has investments in real estate held for future use of $63,501 at June 30, 2018, which is included in other assets.

Acquisitions and Affiliations

The accounting for acquisitions requires extensive use of estimates and judgments to measure the fair value of the identifiable tangible and intangible assets acquired and liabilities assumed. The fair value of acquired tangible and identifiable intangible assets and liabilities assumed are based on their estimated fair values at the acquisition date and are measured using an income and market approach with significant unobservable inputs.

(Dollar Amounts Expressed in Thousands)

2. Summary of Significant Accounting Policies (continued)

On February 1, 2018, the Health System affiliated with Torrance Memorial with a goal of creating an integrated healthcare delivery system to improve the quality of healthcare within their communities and to further their mission of advancing the quality of care and furthering charitable services. The affiliation did not involve consideration and resulted in an excess of assets acquired over liabilities assumed under the business combination accounting guidance, which has been recorded as inherent contribution from affiliation of $625,508 in the consolidated statement of operations and changes in net assets. The Health System recognized fair value estimates of assets acquired and liabilities assumed, and recorded cash and unrestricted investments of $62,986, working capital of $(8,777), property and equipment of $694,706, other assets of $332,462, long-term debt of $385,301, and other liabilities of $70,568.

The following pro forma (unaudited) consolidated financial information presents the Health System's results for the year ended June 30, 2018, assuming the affiliation occurred on July 1, 2017:

	Actual	Pro Forma (Unaudited)
Total revenues	$ 4,365,862	$ 4,870,788
Income from operations	229,138	232,659
Excess of revenues over expenses attributable to the Health System	852,909	876,755
Change in unrestricted net assets	913,537	934,633
Change in temporarily restricted net assets	134,673	150,499
Change in permanently restricted net assets	19,128	19,131

Pro forma results include historical Torrance Health Association, Inc., results (unaudited) for the seven-month period ended January 31, 2018, prior to the affiliation. Purchase accounting adjustments are included within pro forma results. A nonrecurring contribution of $625,508 is included within pro forma results.

(Dollar Amounts Expressed in Thousands)

2. Summary of Significant Accounting Policies (continued)

Goodwill

Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets. Goodwill arising from business combinations is not amortized. The Health System evaluates goodwill on an annual basis and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable. The Health System performs its annual goodwill impairment test on June 30. In the current year we fulfilled the annual impairment test through the use of a qualitative assessment and concluded no indicators of impairment were identified. At June 30, 2018, goodwill, which is included in other assets, totaled $221,415.

Care of the Poor and Community Benefit (Unaudited)

The Health System's mission is to improve the health status of its community, regardless of the patient's ability to pay, including charity patients. The Health System provides programs and activities that contribute to charity care, care of the poor, and community benefit. These programs and activities serve a majority of persons who are beneficiaries of Medi-Cal, and county, state, and federal programs for which the costs of providing the services are not fully reimbursed. Also included are activities that improve the community's health status and educate or provide social services to the elderly and children. The Health System's unreimbursed costs for care of the poor and community benefits were approximately 22.4% of total operating expenses for the year ended June 30, 2018. The costs associated with these programs and activities for the year ended June 30, 2018 are as follows:

Traditional charity care and uninsured patients (Category 1)	$ 27,231
Unpaid cost of state programs (Category 2)	95,402
Unpaid cost of specialty government programs (Category 3)	2,148
Unpaid cost of federal programs (Category 4)	468,740
Research (Category 5)	213,662
Community benefit (Category 6)	118,541
Total community benefit	925,724
A portion of the above cost was supported by the help of:	
Federal, state, and local grants	82,594
Charitable giving	54,461
Community benefit, net of support by others	$ 788,669

2. Summary of Significant Accounting Policies (continued)

The Health System uses the following six categories to classify care of the poor and community benefit:

> Category 1: Traditional Charity Care and Uninsured Patients (care of the poor) – includes the cost of services provided to persons who cannot afford health care because of inadequate resources and/or who are uninsured. If there is any subsidy donated for these services, that amount is deducted from the gross amount.
>
> Category 2: Unpaid Cost of State Programs – also benefits the poor, but is listed separately. This amount represents the unpaid cost of services provided to patients in the Medi-Cal program or enrolled in HMO and Preferred Provider Option (PPO) plans under contract with the Medi-Cal program.
>
> Category 3: Unpaid Costs of Specialty Government Programs – also provides community benefit under such programs as the Veterans Administration, Los Angeles Police Department, Short Doyle, Proposition 99, and other programs to benefit the poor. This amount represents the unpaid cost of services provided to patients in these various programs. If this community benefit was not provided, federal, state, or local governments would need to furnish these services.
>
> Category 4: Unpaid Cost of Federal Programs – primarily benefits the elderly. This amount represents the unpaid cost of services provided to patients in the Medicare program and enrolled in HMO and PPO plans under contract with the Medicare program. Included in these amounts are $24,692 for the year ended June 30, 2018 of unpaid cost of services provided to patients in the Medicare program who are also in the Medi-Cal program.
>
> Category 5: Research – cost of providing translational and clinical research and studies on health care delivery. During the year ended June 30, 2018, the Health System received outside support for its research efforts totaling $137,055. Thus, for the year ended June 30, 2018, the net cost incurred by the Health System was $76,607.
>
> Category 6: Community Benefit – cost of services that are beneficial to the broader community, i.e., other needy populations that may not qualify as poor, but that need special services and support. Examples include the elderly, substance abusers, the homeless, victims of child abuse, and persons with AIDS. They also include the cost of health promotion and education and health clinics and screenings.

2. Summary of Significant Accounting Policies (continued)

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest costs incurred during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment that do not contain explicit donor stipulations, which specify how the donated assets must be used, are reported as unrestricted support, and are excluded from excess of revenue over expenses. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Health System accounts for software development costs in accordance with Accounting Standards Codification (ASC) 350, *Intangibles Goodwill and Other (Topic 350): Internal-use Software*. All costs incurred in the planning stage of developing the software are expensed as incurred, as are internal and external training costs and maintenance costs. External and internal costs, excluding general and administrative costs and overhead costs, incurred during the applicable development stage of internally used software are capitalized. Such costs include external direct costs of materials and services consumed in development or obtaining the software, payroll, and payroll-related costs for employees who are directly associated with and who devote time to developing the software. Development changes that result in appropriate functionality of the software, which enable it to perform tasks that it was previously incapable of performing, are also capitalized.

Capitalized internal-use software development costs are amortized on a straight-line basis over their estimated useful life of three to seven years. Amortization begins when all substantial testing of the software is completed and the software is ready for its intended use.

2. Summary of Significant Accounting Policies (continued)

Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of

The Health System accounts for the impairment and disposition of long-lived assets in accordance with ASC 360, *Property, Plant and Equipment Impairment or Disposal of Long-Lived Assets*. In accordance with ASC 360, long-lived assets to be held are reviewed for events or changes in circumstances that indicate that their carrying value may not be recoverable. The Health System determined that no assets are impaired at June 30, 2018.

Board-Designated Assets

Board-designated assets include investments designated by the Health System’s Board of Directors (the Board) for future capital expenditures, physician programs, academic programs, and fundraising. However, the Board retains control of these assets and will, at its discretion, and if necessary, use these assets for operating purposes. As a result, Board-designated assets are included in current assets.

Assets Limited as to Use

Assets limited as to use include assets held by trustees that are for the payment of self-insurance liabilities, assets with donor restrictions, assets held by trustees under indenture agreement for future capital expenditures, and managed care capitation reserves. The current portion of assets limited as to use includes amounts that will be used to pay self-insurance classified as current liabilities.

Investments

The Health System has designated its investments in equity securities with readily determinable fair values and all investments in debt securities as trading, in accordance with ASC 954, *Health Care Entities*. Those securities are measured at fair value in the accompanying consolidated balance sheet. Fair value is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Management determines the appropriate classification of all investments at the date of purchase and re-evaluates such designations at each consolidated balance sheet date.

2. Summary of Significant Accounting Policies (continued)

Investment income or loss on temporarily restricted net assets (including realized and unrealized gains and losses on investments, interest, and dividends) is reported as unrestricted net assets activity unless the income or loss is restricted by donor or law.

Cedars-Sinai's and Torrance Memorial's investments are invested in accordance with policies approved by its separate Board of Directors, which include, among other matters, targeted investment returns balanced by diversification of the investment portfolio, establishment of credit risk parameters, and limitation in the amount of investment in any single instrument. As part of its investment policies and strategies, each entity's Investment Committee meets periodically to review performance. At least annually, the Investment Committee reviews and formulates a specific investment and allocation plan. Any adjustments that are deemed necessary are based on specific criteria, i.e., the entity's necessary funding, obligations, expenses, and liquidity needs.

Alternative Investments

Certain of the Health System's investments are made through alternative investments, which include investments in limited partnerships and limited liability companies. The Health System generally contracts with fund managers, who have full discretionary authority over investment decisions. The Health System accounts for its ownership interests in the partnerships using the net asset value as a practical expedient for fair value. These investments provide the Health System with a proportionate share of the entities' gains and losses, which are included in investment income on the accompanying consolidated statement of operations and changes in net assets. As of June 30, 2018, these alternative investments comprised approximately 17% of the Health System's total cash, cash equivalents, and investments.

Alternative investments include certain other risks that may not exist with other investments that are more widely traded. These risks include reliance on the skill of the fund managers, who often employ complex strategies with various financial instruments, including futures contracts, foreign currency contracts, structured notes, and other investment vehicles. Additionally, alternative investments may have limited information on a fund's underlying assets and valuation, and limited redemption or redemption-penalty provisions. Management believes that the Health System, in consultation with its Investment Committee, has the capacity to analyze and interpret the risks associated with alternative investments and, with this understanding, has determined that investing in these investments creates a balanced approach to its portfolio management.

2. Summary of Significant Accounting Policies (continued)

Risk Pool Liabilities

Risk pool liabilities include amounts that THA estimates as payable under risk-sharing agreements through analysis of historical claims information using lag schedules and claims turnaround time. The liability also includes amounts payable to medical groups, as well as premiums received that are held in reserve for health plan agreements whose beneficiaries are primarily outside THA's service area. The funding, held in a managed care reserve and included in current portion of assets limited as to use in the accompanying consolidated balance sheet, totaled $78,867 at June 30, 2018.

Medical Malpractice Insurance

Cedars-Sinai is self-insured for the first $3,000 in professional malpractice and general liability losses per occurrence on a claims made basis effective October 1, 2005, and was self-insured for the first $2,000 effective October 1, 2004, and $1,000 for prior periods. Cedars-Sinai purchases excess insurance coverage resulting in total coverage of $200,000 per occurrence, insuring all employees, volunteers, and members of the medical faculty. Effective for the year beginning October 1, 2005, the insurance purchased was excess over an attachment point of $1,000 for each and every claim and another $2,000 per claim with a $10,000 annual aggregate. Effective October 1, 2013, the aggregate was raised to $15,000. Effective October 1, 2015, the aggregate was raised again to $17,000. Cedars-Sinai had no aggregate limit for the three years beginning October 1, 2002. Similarly, Torrance Memorial is self-insured for professional liability (malpractice) claims up to $500 per occurrence on a claims-made basis. Torrance Memorial is covered by hospital malpractice insurance for claims in excess of this amount up to a maximum of $25,000 per occurrence, with an annual aggregate limit of $35,000. Combined accruals for insured and uninsured claims, and claims incurred but not reported are estimated by an actuary based on the Health System's claims experience. Such accruals, which totaled $70,635 at June 30, 2018, are recorded using a 3.0% discount factor at June 30, 2018. The current portion of the accruals of $11,023 is included in accounts payable and other accrued liabilities. The basis for the rate is the risk-free rate of return at the end of each year and the estimated period over which claims will be settled. The accruals represent the total actuarially determined loss without reduction for the portion that is expected to be recoverable through insurance ($11,313 at June 30, 2018). The expected amounts to be recovered through insurance are included in other assets on the accompanying consolidated balance sheet.

2. Summary of Significant Accounting Policies (continued)

Workers' Compensation Insurance

Cedars-Sinai carries workers' compensation insurance insuring employees with a self-insured primary limit of $1,000 effective February 1, 2005 and decreasing amounts in earlier years. Cedars-Sinai purchases excess insurance coverage on an occurrence basis to cover claims in excess of these amounts with an annual aggregate limit of $1,000. THA is also self-insured for workers' compensation claims up to $1,000 through August 31, 2013 and $350 thereafter. THA maintains insurance to cover claims in excess of these amounts with an annual aggregate limit of $1,000. Combined accruals for insured, uninsured claims and claims incurred but not reported are estimated by an actuary based upon the Health System's claims experience. Such accruals, which totaled $116,052 at June 30, 2018, are recorded using a 3.0% discount factor at June 30, 2018. The current portion of the accruals of $24,702 is included in accounts payable and other accrued liabilities. The basis of the rate is the risk-free rate of return at the end of each year and the estimated period over which claims will be settled. The accruals represent the total actuarially determined loss without reduction for the portion that is expected to be recoverable through insurance ($20,109 at June 30, 2018). The expected amounts to be recovered through insurance are included in other assets in the accompanying consolidated balance sheet.

Cash Equivalents

The Health System considers all highly liquid debt instruments with original maturity dates at the time of purchase of three months or less to be cash equivalents.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give cash and indications of intentions to give are not recognized until the conditions are satisfied or removed. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends, or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported on the consolidated statement of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying consolidated financial statements.

2. Summary of Significant Accounting Policies (continued)

Fair Value of Financial Instruments

The Health System's consolidated balance sheet includes the following financial instruments: cash and cash equivalents, investments, patient accounts receivable, accounts payable and other accrued liabilities, pension liabilities, and long-term obligations. The Health System considers the carrying amounts of current assets and liabilities in the consolidated balance sheet to approximate the fair value of these financial instruments because of the relatively short period of time between origination of the instruments and their expected realization. Pledge receivable, accrued workers' compensation, malpractice insurance claims, and pension liabilities are recorded at their estimated present value using appropriate discount rates. Marketable securities are recorded at fair value based on quoted prices from recognized security exchanges and other methods, as further described in Note 5. Alternative investments are recorded at net asset value, which represents a practical expedient of fair value. Tax-exempt financings are carried at amortized cost. The fair value of tax-exempt financings is estimated based on current market rates, as further described in Note 4.

Income Taxes

The Health System and its related affiliates have been determined to qualify as exempt from federal and state income taxes under Section 501(a) as organizations described in Section 501(c)(3) of the Code.

Most of the income received by the Health System is exempt from taxation, as income related to the mission of the organization. Accordingly, there is no material provision for income taxes for these entities. However, some of the income received by the exempt entities is subject to taxation as unrelated business income. The Health System and its subsidiaries file federal and state income tax returns.

The Health System completed an analysis of its tax positions, in accordance with ASC 740, *Income Taxes*, and determined that there are no uncertain tax positions taken or expected to be taken. The Health System has recognized no interest or penalties related to uncertain tax positions. The Health System is subject to routine audits by the taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Health System believes it is no longer subject to income tax examinations for years prior to 2015.

(Dollar Amounts Expressed in Thousands)

2. Summary of Significant Accounting Policies (continued)

The Tax Cuts and Jobs Act (the Act) was enacted on December 22, 2017. The provisions of the Act did not have a material tax effect on the Health System's consolidated financial statements. Certain regulatory guidance provides for a measurement period of up to one year during which accounting for the tax effects of the Act may be completed. The Health System will continue to evaluate the impact of the Act and may record adjustments as additional information and guidance is released by the Internal Revenue Service.

Concentrations of Credit Risk

Financial instruments, which potentially subject the Health System to concentrations of credit risk, consist primarily of investments and accounts receivable. Investments are made in a variety of financial instruments with prudent diversification requirements. The Health System seeks diversification among its investments by limiting the amount of investments that can be made with any one obligor. The investment portfolio is managed by professional investment managers within the guidelines established by the Board, which, as a matter of policy, limit the amounts that may be invested in any one issuer.

The Health System grants credit without collateral to its patients, most of whom are area residents and are insured under third-party agreements. The mix of net receivables from patients and third-party payers as of June 30, 2018 is as follows:

Medicare	18%
Medi-Cal	2
Commercial and managed care	73
Self-pay and other	7
	100%

Recent Accounting Pronouncements

In March 2017, the Financial Accounting Standards Board (the FASB) issued Accounting Standards Update (ASU) 2017-07, *Compensation – Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, which requires entities to (1) disaggregate the current-service-cost component from the other components of net benefit cost (the other components) and present it with other current compensation costs for related employees in the income statement and (2) present the other

2. Summary of Significant Accounting Policies (continued)

components elsewhere in the income statement and outside of income from operations if that subtotal is presented. ASU 2017-07 is effective for annual periods beginning after December 15, 2017. The Health System does not anticipate that the implementation will have a material impact on the consolidated financial statements.

In January 2017, the FASB issued ASU 2017-04, *Intangibles – Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*, which removes the requirement to compare the implied fair value of goodwill with its carrying amount as part of step 2 of the goodwill impairment test. As a result of the ASU, an entity should perform its annual, or interim, goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount and should recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value; however, the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. ASU 2017-04 is effective prospectively for fiscal years beginning after December 15, 2019. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The Health System does not anticipate that the implementation will have a material impact on the consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, *Business Combinations (Topic 805): Clarifying the Definition of a Business*, to clarify the definition of a business in ASC 805, *Business Combinations*. The amendments narrow the definition of a business and provide a framework that gives entities a basis for making reasonable judgments about whether a transaction involves an asset or a business. ASU 2017-01 is effective for annual periods beginning after December 15, 2017, including interim periods therein. The ASU must be applied prospectively on or after the effective date, and no disclosures for a change in accounting principle are required at transition. Early adoption is permitted for transactions (i.e., acquisitions or dispositions) that occurred before the issuance date or effective date of the standard if the transactions were not reported in financial statements that have been issued or made available for issuance. The Health System does not anticipate that the implementation will have a material impact on the consolidated financial statements.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*, which amends ASC 230 *Statement of Cash Flows* to add or clarify guidance on the classification and presentation of restricted cash on the statement of cash flows. The standard will require an entity to include in its cash and cash equivalent balances on the statement of cash flows those amounts that are deemed to be restricted cash and restricted cash equivalents as well

2. Summary of Significant Accounting Policies (continued)

as to disclose a reconciliation between the statement of financial position and the statement of cash flows when the statement of financial position includes more than one line item for cash, cash equivalents, restricted cash, and restricted cash equivalents. ASU 2016-18 is effective for fiscal years beginning after December 15, 2017. The Health System does not anticipate that the implementation will have a material impact on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*, which amends the guidance in ASC 230 on the classification of certain cash receipts and payments on the statement of cash flows. The amendments will add or clarify guidance on various cash flow issues, including debt prepayment or debt extinguishment costs as well as distributions received from equity method investees. ASU 2016-15 is effective for fiscal years beginning after December 15, 2017. The Health System does not anticipate that the implementation will have a material impact on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements for Not-For-Profit Entities*, which will require not-for-profit entities to revise financial presentation to include net asset classifications, provide quantitative and qualitative information as to available resources and management of liquidity and liquidity risk, information on investment expenses and returns, and the presentation of operating cash flows. The standard aims to help the reader of the financial statements to better understand the financial position of the organization and enhance consistency among similar organizations. ASU 2016-14 is effective for annual periods beginning after December 15, 2017. The Health System does not anticipate that the implementation will have a material impact on the consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842): Amendments to the FASB Accounting Standards Codification*. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The standard is effective for fiscal years beginning after December 15, 2018. Early adoption of the amendments is permitted for all entities. The Health System is currently evaluating the impact of this new standard on the consolidated financial statements.

(Dollar Amounts Expressed in Thousands)

2. Summary of Significant Accounting Policies (continued)

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities,* a new accounting standard that amends the accounting and disclosures of financial instruments, including a provision that requires equity investments (except for investments accounted for under the equity method of accounting) to be measured at fair value, with changes in fair value recognized in current earnings. The new standard is effective for annual periods beginning after December 15, 2018. The Health System is currently evaluating the impact of this new standard on the consolidated financial statements.

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU 2014-09 provides a single, comprehensive revenue recognition model for entities to use in accounting for revenue arising from contracts with customers. The standard requires the entity to recognize revenue for the transfer of goods or services equal to the amount that it expects to be entitled to receive for those goods or services. The standard, as amended by ASU 2015-14, *Revenue from Contracts with Customers,* is effective for periods beginning after December 15, 2017. The Health System expects to adopt the standard under the modified retrospective method and does not anticipate that the implementation will have a material impact on the consolidated financial statements.

3. Property and Equipment

Property and equipment consist of the following at June 30, 2018:

Land	$ 258,962
Buildings and land improvements	3,026,224
Equipment	560,269
Software and software implementation costs	647,866
	4,493,321
Less accumulated depreciation and amortization	1,786,540
	2,706,781
Construction-in-progress	329,708
	$ 3,036,489

Depreciation and amortization expense on property and equipment was $211,630 for the year ended June 30, 2018.

(Dollar Amounts Expressed in Thousands)

3. Property and Equipment (continued)

Construction-in-progress consists of the following at June 30, 2018:

Buildings and land improvements	$ 245,659
Equipment	9,567
Software and software implementation costs	67,651
Capitalized interest	6,831
	$ 329,708

If each project included in construction-in-progress were placed in service at June 30, 2018, at the costs capitalized at that date, the Health System's annual depreciation would increase by approximately $20,956 (unaudited). This estimate of incremental annual depreciation is subject to change as additional costs are incurred to complete these projects. The Health System estimates that it will cost approximately $527,562 (unaudited) to complete the projects currently under construction.

4. Long-Term Debt

Cedars-Sinai and Torrance Memorial have public bonds. The entities do not assume any financial obligations related to payment of debt issued by each other. Revenue of each entity (excluding its affiliated or subsidiary organizations) is pledged to secure the payment of the principal and interest on all bonds and certificates under its separate Master Trust Indentures (Indentures). The Indentures contain covenants restricting additional debt and providing for the maintenance of certain financial ratios. Both entities were in compliance with these covenants at June 30, 2018.

(Dollar Amounts Expressed in Thousands)

4. Long-Term Debt (continued)

Long-term debt issued and outstanding at June 30, 2018 is as follows:

Cedars-Sinai		
$535,000 Revenue Bond, Series 2009; principal payments of $1,045 to $68,860 are due annually through 2039; interest is payable semiannually at 3.5% to 5.0%; the amount reported includes a face value of $16,960, unamortized premiums of $0 and unamortized deferred financing costs of $0;	$	16,960
$148,400 Revenue Bond, Series 2011; principal payments of $9,845 to $18,900 are due annually through 2021; interest is payable semiannually at 3.0% to 5.0%; the amount reported includes a face value of $73,860, unamortized premium of $2,213 and unamortized deferred financing costs of $217		75,856
$370,220 Revenue Bond, Series 2015; principal payments of $480 to $39,680 are due annually through 2035; interest is payable semiannually at 2.0% to 5.0%; the amount reported includes a face value of $368,120, unamortized premium of $53,174 and unamortized deferred financing costs of $1,951		419,343
$267,420 Revenue Bond, Series 2016A; principal payments of $5,040 to $38,905 are due annually through 2036; interest is payable semiannually at 4.0% to 5.0%; the amount reported includes a face value of $261,255, unamortized premiums of $46,199 and unamortized deferred financing costs of $1,343		306,111
$402,305 Revenue Bond, Series 2016B; principal payments of $1,625 to $66,900 are due annually beginning in 2020 through 2039; interest is payable semiannually at 3.0% to 5.0%; the amount reported includes a face value of $402,305, unamortized premiums of $30,038 and unamortized deferred financing costs of $2,184		430,159
Other notes payable, secured by deeds of trust		15,507
Capital leases		930
Cedars-Sinai total	$	1,264,866

(Dollar Amounts Expressed in Thousands)

4. Long-Term Debt (continued)

Torrance Memorial		
$135,000 Revenue Bonds, Series 2010A; principal payments of $1,910 to $12,290 are due annually through 2040; interest is payable semiannually at 3.0% to 5.0%; the amount reported includes a face value of $131,119, unamortized premium of $6,939 and unamortized deferred financing costs of $1,553	$	136,505
$64,860 Revenue Bonds, Series 2010B; principal payments are due semiannually through 2045; interest is payable based on a variable rate ranging from 1.48% to 1.62%; the amount reported includes a face value of $63,985, unamortized discount of $0 and unamortized deferred financing costs of $825		63,160
$35,140 Revenue Bonds, Series 2010C; principal payments are due semiannually through 2045; interest is payable semiannually based on a variable rate ranging from 1.48% to 1.62%; the amount reported includes a face value of $34,655, unamortized discount of $0 and unamortized deferred financing costs of $448		34,207
$34,795 Revenue Notes, Series 2016A; principal payments of $2,020 to $2,700 are due annually through 2026; interest is payable semiannually at 2.4%; the amount reported includes a face value of $32,775, unamortized discount of $518 and unamortized deferred financing costs of $186		32,071
$30,000 Revenue Notes, Series 2016B; principal payments of $2,770 to $3,285 are due annually through 2026; interest is payable semiannually at 2.3%; the amount reported includes a face value of $27,250, unamortized discount of $460 and unamortized deferred financing costs of $175		26,615
Other notes payable		505
Torrance Memorial total		293,063
Cedars-Sinai and Torrance Memorial total		1,557,929
Less current maturities for Cedars-Sinai and Torrance Memorial		50,783
	$	1,507,146

4. Long-Term Debt (continued)

In November 2016, Cedars-Sinai Medical Center issued $669,725 of California Health Facilities Financing Authority Revenue Bonds, composed of the 2016A Series Revenue Bonds totaling $267,420 and the 2016B Series Revenue Bonds totaling $402,305. The proceeds totaled $755,157, including a premium on the 2016A Series Revenue Bonds of $52,585 and a premium on the 2016B Series Revenue Bonds of $32,847, both of which will be amortized as a reduction of interest expense over the life of the bonds. Total issuance costs of $3,975 were incurred in connection with the offerings. The proceeds from the 2016A Series Revenue Bonds were used to finance the costs of future capital expenditures, including the purchase of an administrative office building (including the land) that was previously leased by Cedars-Sinai Medical Center. The proceeds from the 2016B Series Revenue Bonds were used to advance refund the majority of the 2009 Series Revenue Bonds that were callable totaling $392,605. The remaining, unrefunded portion of the 2009 Series Revenue Bonds totaled $16,960 as of June 30, 2018.

In November 2015, Cedars-Sinai Medical Center issued $370,220 of California Health Facilities Financing Authority Revenue Bonds. The proceeds totaled $438,580, including a premium of $68,360 which will be amortized as a reduction of interest expense over the life of the bonds. Issuance costs of $2,540 were incurred in connection with the offering. The proceeds were used to fully pay down the 2005 Series Revenue Bonds.

In December 2012, Cedars-Sinai Medical Center entered into a $50,000 credit agreement (the Agreement) with a bank that will expire in February 2023. Cedars-Sinai Medical Center may borrow under the Agreement with interest charged at either the London Interbank Offered Rate (LIBOR) plus an applicable margin of 0.375% based on Cedars-Sinai Medical Center's Moody's rating (currently Aa3), or at the greater of the bank's fluctuating prime rate minus 1.5%, or 1.0%. At June 30, 2018, the three-month LIBOR was 2.3% and the bank's prime rate was 5.0%. Cedars-Sinai Medical Center also pays a 0.125% annual commitment fee on the unused credit line. The Agreement is secured on a parity basis under the Bond Indenture with the tax-exempt financings of Cedars-Sinai Medical Center. No amounts have been borrowed under the Agreement.

In November 2013, Cedars-Sinai Medical Center entered into a second $50,000 credit agreement with another bank that will expire in November 2018. The terms are substantially similar to the Agreement described above, except the commitment fee on the unused credit line is .075% as of June 30, 2018, and the applicable margin is 0.6% based on Cedars-Sinai Medical Center's maintaining its Moody's rating. No amounts have been borrowed under this agreement.

4. Long-Term Debt (continued)

In December 2016, TMMC refunded the City of Torrance 2001 Series A Bonds with an aggregate principal amount of $44,865. The City of Torrance also issued Series 2016 A and 2016 B Revenue Notes for an aggregate principal amount of $64,795. The 2016 Series A and Series B Notes were issued to refund the 2001 Series A Bonds and to finance a portion of the costs of constructing and equipping certain additions and improvements to the facilities operated by TMMC. The 2016 Series A and Series B Notes mature on December 1, 2026.

In September 2010, the City of Torrance issued Series 2010 A, 2010 B, and 2010 C Bonds for an aggregate principal amount of $235,000. The 2010 Series A and Series B Bonds were issued to assist in financing the construction of the new patient tower. The 2010 Series C Bonds were issued to refund the 1992 Bonds. As of June 30, 2018, the weighted-average interest rate on the 2010 Series A Bonds was 4.86%. The interest rate for the 2010 Series B and 2010 Series C Bonds at June 30, 2018 was 3.1%.

In June 2015, TMMC entered into a direct purchase agreement with JP Morgan for the 2010 Series B and 2010 Series C bonds. Under terms of this agreement, JP Morgan purchased the entire amount of the two issuances at face value. The interest rate mode was changed from variable rate demand bonds that priced weekly to a semi-variable interest rate formula that is a function of the one-month LIBOR and reprices monthly. The term of the direct purchase is for a four-year period, after which JP Morgan has the option to continue or to exit the direct purchase relationship. The agreement was renewed in July 2018. The underlying line of credit backing the issuances was canceled. Other significant terms and covenants of the debt remain substantially the same.

As a result of the affiliation, the Health System recorded a premium of $6,044 for TMMC's bonds to present the fair value of the bonds at the acquisition date. The premium will be amortized as a reduction of interest expense over the life of the bonds.

The fair value of the tax-exempt financings for the Health System, determined using Level 2 inputs (refer to Note 5 for description) primarily related to comparable market prices, was estimated to be $1,551,219 at June 30, 2018.

(Dollar Amounts Expressed in Thousands)

4. Long-Term Debt (continued)

The combined aggregate amount of maturities and sinking fund requirements (excluding the unamortized premium of $137,585 and unamortized deferred financing costs of $8,882 at June 30, 2018) for the five fiscal years succeeding June 30, 2018 and thereafter is as follows:

2019	$ 39,015
2020	41,060
2021	41,560
2022	43,455
2023	45,445
Thereafter	1,218,691
	$ 1,429,226

For the year ended June 30, 2018 interest costs incurred totaled $47,474, of which $6,831 was capitalized as part of the cost of construction-in-progress.

5. Retirement Plans

During 1990, the Board of Directors of Cedars-Sinai authorized the suspension of Cedars-Sinai's non-contributory, defined benefit plan, which covered substantially all eligible employees (the Suspended Employee Plan). Benefit accruals under the Suspended Employee Plan were suspended effective December 31, 1990. Effective July 1, 2003, Cedars-Sinai began offering a defined benefit plan to its employees. Rather than design a new plan, Cedars-Sinai amended the Suspended Employee Plan (the Cedars-Sinai Defined Benefit Plan) to capture the new defined benefit activity.

During 1991, Cedars-Sinai implemented a defined contribution plan (the Cedars-Sinai Defined Contribution Plan), covering substantially all employees covered under the Suspended Employee Plan. Contributions under the Cedars-Sinai Defined Contribution Plan are calculated based on each employee's salary and totaled $72,732 for the year ended June 30, 2018. Employees have the choice of participation in either the Cedars-Sinai Defined Benefit Plan or the Cedars-Sinai Defined Contribution Plan and can change the selection once during their employment.

5. Retirement Plans (continued)

Cedars-Sinai employees participate in a 403(b) plan sponsored by Cedars-Sinai. Under the provisions of the plan, participating employees may make voluntary contributions up to 100% of pretax annual compensation, subject to statutory limitations. Cedars-Sinai contributes 50% of the first 6% of compensation that a participant contributes to the plan.

In addition, certain key employees of Cedars-Sinai are covered by separate defined contribution and defined benefit retirement plans, which are not governed by the Employee Retirement Income Security Act of 1974. Contributions under these plans are calculated based on each key employee's salary and totaled $21,873 for the year ended June 30, 2018.

Torrance Memorial has a noncontributory defined benefit retirement plan (the THA Defined Benefit Plan) under which employees, upon retirement, are provided a monthly pension if conditions related to age and length of service have been met. During 2009, Torrance Memorial adopted an amendment, effective January 1, 2010, that reduces benefits accrued under plan provisions and freezes participation in the THA Defined Benefit Plan to those individuals employed by Torrance Memorial on or before December 31, 2009. Individuals employed subsequent to this date become eligible for participation in a defined contribution plan, to be funded 100% by Torrance Memorial.

On January 1, 2010, Torrance Memorial began a new 401(a) defined contribution plan (THA 401(a) Plan). Torrance Memorial employees hired on or after January 1, 2010, and who are at least 21 years of age, are eligible to participate in the THA 401(a) Plan. Under the provisions of the plan, employees become members on January 1 or July 1, whichever is sooner, following the completion of one year of employment in which the employee was credited with at least 1,000 hours of service. Contributions to the plan are made entirely by Torrance Memorial and range from 3% to 6% of annual compensation, based on years of service. Contributions to employee accounts vest based upon years of service, with accounts becoming fully vested upon completion of five years of service with Torrance Memorial. Torrance Memorial's contributions to the plan amounted to approximately $1,243 for the five months ended June 30, 2018.

Torrance Memorial's employees participate in a 403(b) plan sponsored by THA. Under the provisions of the plan, participating employees may make voluntary contributions through salary deductions. Torrance Memorial matches eligible employee contributions at rates between 20% to 100% with a maximum limit of eight hundred dollars per year based upon years of service with Torrance Memorial. Torrance Memorial's contributions related to the 403(b) plan amounted to approximately $490 for the five months ended June 30, 2018.

(Dollar Amounts Expressed in Thousands)

5. Retirement Plans (continued)

Torrance Memorial participates in a nonqualified 457(b) deferred compensation plan, which was established in 2003. The plan permits a defined group of management employees to make voluntary contributions through salary deductions up to the maximum amount allowed by law. Torrance Memorial did not contribute or match any contributions to this plan during the five months ended June 30, 2018.

The following tables present information related to changes in projected benefit obligations, plan assets and their composition, funded status, the accumulated benefit obligation, and net periodic pension cost for all Cedars-Sinai and THA defined benefit plans (the Plans) at June 30, 2018, and for the year then ended. Cedars-Sinai contributed $2,025 to fully fund the Cedars-Sinai Defined Benefit Plan in September 2018.

In addition, Torrance Memorial has recorded liabilities for pension benefits of $4,795 as of June 30, 2018, relating to Torrance Memorial's other retirement plans.

	Cedars- Sinai	THA	Total
Change in projected benefit obligations:			
Projected benefit obligation at beginning of year	$ 554,332	$ 415,022	$ 969,354
Service cost	38,277	6,848	45,125
Interest cost	21,502	6,258	27,760
Actuarial gains	(31,149)	(22,608)	(53,757)
Benefits paid	(14,045)	(4,999)	(19,044)
Settlement	(13,148)	–	(13,148)
Projected benefit obligation at end of year	555,769	400,521	956,290
Change in plan assets:			
Fair value of plan assets at beginning of year	488,819	363,775	852,594
Actual gain (loss) on plan assets	29,491	(7,757)	21,734
Employer contributions	52,253	8,650	60,903
Benefits paid	(14,045)	(4,999)	(19,044)
Expenses paid	(1,124)	–	(1,124)
Settlement	(13,148)	–	(13,148)
Fair value of plan assets at end of year	542,246	359,669	901,915
Funded status	$ (13,523)	$ (40,852)	$ (54,375)

(Dollar Amounts Expressed in Thousands)

5. Retirement Plans (continued)

	Cedars-Sinai	THA
Composition of plan assets:		
Short-term money market funds	21%	8%
Government and corporate debt	–	29
Equity securities	4	27
Mutual funds	75	33
Common/collective trusts	–	3
	100%	100%

	Cedars-Sinai	THA	Total
Amounts recognized as pension liability in the consolidated balance sheet	$ 13,523	$ 40,852	$ 54,375
Accumulated benefit obligation	$ 525,133	$ 377,653	$ 902,786

	Cedars-Sinai	THA	Total
Net periodic benefit cost recognized:			
Service cost	$ 38,277	$ 6,848	$ 45,125
Interest cost	21,502	6,258	27,760
Expected return on plan assets	(29,716)	(9,890)	(39,606)
Amortization of net loss	14,674	–	14,674
Amortization of prior service costs	270	–	270
Net periodic benefit cost	$ 45,007	$ 3,216	$ 48,223

	Cedars-Sinai	THA
Weighted average assumptions used to determine benefit obligations consist of the following:		
Discount rate used to determine service cost	4.00%	4.02%
Discount rate used to determine projected benefit obligation	4.31	4.33
Expected long-term rate of return on plan assets	5.75	6.50
Rate of increase in future compensation levels	4.00	4.00

(Dollar Amounts Expressed in Thousands)

5. Retirement Plans (continued)

The expected rate of return on plan assets is updated annually, taking into consideration the Plans' asset allocation, historical returns on the types of assets held in the trusts, and the current economic environment.

Amounts included in unrestricted net assets that have not been recognized in net periodic pension cost as of June 30, 2018:

	Cedars-Sinai	THA	Total
Unrecognized prior service costs	$ 1,147	$ –	$ 1,147
Unrecognized prior loss (gain)	130,531	(4,961)	125,570
	$ 131,678	$ (4,961)	$ 126,717

The unrecognized prior losses and unamortized prior service costs expected to be recognized over the fiscal year ending June 30, 2019 are $8,044 and $270, respectively, for the Cedars-Sinai Defined Benefit Plan and $0 and $0, respectively, for the THA Defined Benefit Plan.

Plans Assets

Approximately 95% of plan assets relate to long-term investment activities covering the Health System's general employee population. The other 5% of the assets relates to a special plan for highly compensated employees closer to retirement age. The combined target allocation is approximately 65% equities, 25% fixed income, and 10% short-term instruments, with no allocation to alternative investments. All investments are highly liquid.

The Health System uses a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is 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.

(Dollar Amounts Expressed in Thousands)

5. Retirement Plans (continued)

- 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 instruments. This includes model-derived valuations whose significant inputs are observable.

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

Fair values are based on one or more of three valuation techniques. The valuation techniques are as follows:

a) Market approach. Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities.

b) Cost approach. Amount that would be required to replace the service capacity of an asset (replacement cost).

c) Income approach. Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option pricing, and excess earnings models).

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 following table presents the financial instruments in the Cedars-Sinai Defined Benefit Plan and THA Defined Benefit Plan carried at fair value as of June 30, 2018, by valuation hierarchy.

	Level 1	Level 2	Total	Valuation Technique (a, b, c)
Cash and cash equivalents	$ 141,000	$ –	$ 141,000	a
Equities	121,306	–	121,306	a
U.S. government issues	43,765	–	43,765	a
Corporate bonds	–	61,903	61,903	a
Mutual funds	521,497	–	521,497	a
Common/collective trusts	–	12,444	12,444	a
	$ 827,568	$ 74,347	$ 901,915	

5. Retirement Plans (continued)

Plans' Investment Strategy

The Health System's investment policy generally reflects the long-term nature of the pension plans' funding obligations. Assets are invested to achieve a rate of return consistent with policy allocation targets, which significantly contributes to meeting the current and future obligations of the plans, and strives to help ensure solvency of the plans over time. This objective is to be achieved through a well-diversified asset portfolio and emphasis on long-term capital appreciation as a primary source of return. The plans utilize a multi-manager structure of complementary investment styles and classes. Manager qualitative performance is continually evaluated, while a manager's investment performance is judged over an investment market cycle of at least three years.

Plans assets are exposed to risk and fluctuations in market value from year to year. To minimize risk, each manager maintains a diversification of their portfolio to insulate the portfolio from substantial losses in any single security or sector of the market. The asset allocation is reviewed for deviations in the allowable range for each asset class, and rebalancing is implemented as necessary.

The long-term rate of return of the plans' investment allocation is designed to be commensurate with a conservatively managed balance allocation. Fixed-income securities consist ofinvestment-grade bonds.

Each investment type is managed by an asset manager specializing in various security types. The investment objective of the plans over a three- to five-year period is to produce a rate of return that equals or exceeds the appropriate bond index, S&P 500 stock index, or other appropriate international equity index.

As part of investment policies and strategies, the plans' Investment and Pension Committees meet periodically to review performance. At least annually, the Investment and Pension Committees review and formulate the specific investment and allocation plan. Any adjustments that are deemed necessary are based on specific criteria, i.e., necessary plan funding, plan obligations, plan expenses, and plan liquidity needs.

(Dollar Amounts Expressed in Thousands)

5. Retirement Plans (continued)

Plans' Cash Flows

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

	Cedars-Sinai	THA	Total
2019	$ 20,240	$ 14,874	$ 35,114
2020	21,447	14,708	36,155
2021	23,554	16,153	39,707
2022	25,704	17,637	43,341
2023	27,810	19,054	46,864
2024 through 2027	168,082	114,393	282,475

6. Investments

Investment loss or income on cash and cash equivalents, investments, board-designated assets, and assets limited as to use consists of the following for the year ended June 30, 2018:

Interest and dividend income	$ 53,689
Realized gains	87,873
Unrealized losses	(18,736)
Investment gain included in the consolidated statement of operations and changes in net assets	$ 122,826

The following table presents the financial instruments carried at fair value as of June 30, 2018, by valuation hierarchy as defined in Note 5. Alternative investments are recorded at net asset value, which is a practical expedient for fair value. The alternative investments are redeemable monthly, quarterly, semiannually, annually, or at the end of the term.

There were no significant transfers between Levels 1, 2, or 3 during the year ended June 30, 2018. See Note 5 for a description of the valuation techniques.

(Dollar Amounts Expressed in Thousands)

6. Investments (continued)

	Level 1	Level 2	Fair Value	Valuation Technique (a, b, c)
June 30, 2018:				
Cash and cash equivalents in assets limited to use	$ 21,796	$ –	$ 21,796	a
Equities	439,528	–	439,528	a
U.S. government debt	901,316	12,053	913,369	a
Corporate debt (domestic)	–	291,345	291,345	a
Foreign government debt	–	41,239	41,239	a
Mutual funds and other	701,846	–	701,846	a
	$ 2,064,486	$ 344,637	2,409,123	
Alternative investments measured at net asset value			560,905	
			$ 2,970,028	

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes:

Health care services	$ 322,445
Purchase of capital assets	15,072
Health education and research	140,632
	$ 478,149

During the year ended June 30, 2018, net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes of health care services and health education totaling $198,434, and capital expenditures and contributions totaling $4,452.

Permanently restricted assets and net assets at June 30, 2018 are restricted to investments that are to be held in perpetuity to provide a permanent source of income.

(Dollar Amounts Expressed in Thousands)

7. Temporarily and Permanently Restricted Net Assets (continued)

Pledges are recognized as contributions at the present value of expected future payments. The discount rate used is the estimated risk-free discount rate at the time of the donation (ranging from 1.08% to 13.82%). Pledges receivable in temporarily and permanently restricted net assets are scheduled to be received as follows:

Due in one year or less	$ 33,015
Due after one year through five years	99,820
Due after five years	145,485
Total balance, less allowance of $18,071	278,320
Less discount to present value	52,524
Pledges receivable, net	$ 225,796

During the year ended June 30, 2018, the Health System had the following endowment-related activities:

	Permanently Restricted	Unrestricted	Total
Endowment net assets, beginning of year	$ 309,320	$ 444,430	$ 753,750
Contributions	15,815	8,283	24,098
Inherent contribution from affiliation	3,313	–	3,313
Investment income	2,039	33,538	35,577
Transfers of investment income to unrestricted funds	(2,039)	(1,668)	(3,707)
Endowment net assets, end of year	$ 328,448	$ 484,583	$ 813,031

The Health System's endowment consists of 229 individual funds for a variety of purposes. Its endowment includes both donor-restricted endowment funds and funds designated by the Board to function as endowments. As required by U.S. GAAP, net assets associated with endowment funds, including funds designated by the Board to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

7. Temporarily and Permanently Restricted Net Assets (continued)

The Health System's Board has interpreted the Uniform Prudent Management of Institutional Funds Act as requiring the preservation of the corpus of the various donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Health System classifies as permanently restricted net assets (a) the original value of gifts donated, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund.

The Health System has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowments. Endowment assets include those assets of donor-restricted funds that the organization must hold in perpetuity, as well as Board-designated funds. Under this policy, as approved by the Board, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield of market benchmarks. Actual returns in any given year may vary from this goal.

To satisfy the long-term rate of return objectives, the Health System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Health System targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term objectives within prudent constraints.

8. Commitments and Contingencies

Pending claims and legal proceedings at June 30, 2018 are set forth below. For all matters where a loss is probable and reasonably estimable, an estimate of the loss or a range of loss is provided. Where no estimate is provided, a loss is not probable or an amount of loss is not reasonably estimable at this time.

Litigation – Employment Practices (Class Action). Wage and hour complaints have multiplied in the hospital field in the last few years. The Health System is now defending a series of separate cases which in various forms contend that there has been a failure to pay overtime wages; failure to pay minimum wages; failure to provide meal periods or compensation in lieu thereof; failure to provide rest periods or compensation in lieu thereof; failure to pay wages in a timely manner at separation; failure to provide accurate itemized wage statements; and/or unfair business practices.

8. Commitments and Contingencies (continued)

These cases have been assigned to the “complex” division of the Superior Court. Outside counsel has been retained to defend these cases and the Health System will vigorously defend the class action function and other allegations. The cost and outcome of these cases cannot be ascertained at this time.

Other. In addition to the above, the Health System is a defendant in various other legal actions arising from the normal conduct of business. Management believes that the ultimate resolution of all proceedings will not have a material adverse effect upon the consolidated financial position, results of operations, or cash flows of the Health System. Further, new claims or inquiries may be initiated against the Health System and its affiliates from time to time. These matters could (1) require the Health System to pay substantial damages or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under the insurance policies where coverage applies and is available; (2) cause the Health System to incur substantial expenses; and (3) require significant time and attention from management.

The Health System cannot predict the results of current or future claims and lawsuits. The Health System recognizes that, where appropriate, the Health System’s interests may be best served by resolving certain matters without litigation. If a non-litigated resolution is not appropriate or possible with respect to a particular matter, the Health System will defend itself vigorously. The ultimate resolution of claims against the Health System, individually or in the aggregate, could have a material adverse effect on the Health System’s business (both in the near and long term), consolidated financial position, results of operations, or cash flows.

(Dollar Amounts Expressed in Thousands)

8. Commitments and Contingencies (continued)

The Health System leases certain office space under the terms of non-cancelable operating leases, whose terms vary in length from month to month to 15 years, with renewal options upon prior written notice, typically for 5 years depending upon the agreed-upon terms with the local landlord. Rents under the Health System's lease amounts generally increase from 2% to 5% on an annual basis. Future minimum lease commitments under non-cancelable operating leases are as follows:

2019	$ 71,018
2020	67,526
2021	61,722
2022	54,466
2023	45,594
Thereafter	206,949
	$ 507,275

Rental expense was $92,002 during the year ended June 30, 2018.

9. Functional Expenses

The Health System provides general health care services to residents within its geographic location. Expenses related to providing these services for the year ended June 30, 2018 are as follows:

Health care services	$ 3,620,363
General and administrative	504,419
Fundraising	11,942
	$ 4,136,724

10. Subsequent Events

The Health System evaluated subsequent events through October 29, 2018, which is the date these consolidated financial statements were issued.

Reports Required by the Uniform Guidance

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Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Management and the Board of Directors
Cedars-Sinai Health System

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Cedars-Sinai Health System, which comprise the consolidated balance sheet as of June 30, 2018, and the related consolidated statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated October 29, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Cedars-Sinai Health System's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Cedars-Sinai Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of Cedars-Sinai Health System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Cedars-Sinai Health System's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct, and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

October 29, 2018

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Report of Independent Auditors on Compliance for the Major Federal Program and Report on Internal Control Over Compliance Required by the Uniform Guidance

Management and the Board of Directors
Cedars-Sinai Health System

Report on Compliance for Each Major Federal Program

We have audited Cedars-Sinai Health System's compliance with the types of compliance requirements described in the US Office of Management and Budget's (OMB) *Compliance Supplement* that could have a direct and material effect on Cedars-Sinai Health System's major federal program for the year ended June 30, 2018. Cedars-Sinai Health System's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for Cedars-Sinai Health System's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Costs Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Cedars-Sinai Health System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of Cedars-Sinai Health System's compliance.

Opinion on the Major Federal Program

In our opinion, Cedars-Sinai Health System complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2018.

Report on Internal Control Over Compliance

Management of Cedars-Sinai Health System is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered Cedars-Sinai Health System's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Cedars-Sinai Health System's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

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The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Ernst & Young LLP

January 16, 2019

Supplementary Information

Cedars-Sinai Health System

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2018

Federal Grantor/Program or Cluster Title/Pass Through Grantor	CFDA No.	Pass Through Grantor Identifying No.	Federal Expenditures	Expenditures to Subrecipients
Research and Development Cluster				
Department of Commerce National Institute of Standards and Technology (NIST)				
Arrangements for Interdisciplinary Research Infrastructure	11.619		$ 192,122	$ –
Total Department of Commerce National Institute of Standards and Technology (NIST)			**192,122**	**–**
Department of Defense				
Military Medical Research and Development	12.420		8,895,424	55,542
Pass Through-Duke University	12.420	W81XWH-12-1-0447	(88,182)	–
Pass Through-Duke University	12.420	W81XWH-14-1-0111	104,806	–
Pass Through-Johns Hopkins University School of Medicine	12.420	W81XWH-12-1-0588	3,303	–
Pass Through-University of California Los Angeles	12.420	W81XWH-14-1-0602	1,463	–
Pass Through-University of California Los Angeles	12.420	W81XWH-16-1-0092	66,294	–
Pass Through-University of Florida	12.420	W81XWH-17-2-0030	190,351	–
Pass Through-University of Southern California	12.420	W81XWH-17-1-0612	9,153	–
Pass Through-Vanderbilt University Medical Center	12.420	W81XWH-15-1-0259	75,204	–
Total Pass Through-Military Medical Research and Development			362,392	–
Total Military Medical Research and Development			9,257,816	55,542
Total Department of Defense			**9,257,816**	**55,542**
National Science Foundation				
Social, Behavioral, and Economic Sciences	47.075		39,381	–
Total National Science Foundation			**39,381**	**–**
Department of Health and Human Services				
Family Smoking Prevention and Tobacco Control Act Regulatory	93.077		273,196	–
Oral Diseases and Disorders Research	93.121		(58,209)	–
Pass Through-University of Rochester	93.121	R01 DE019902	330,418	–
Total Oral Diseases and Disorders Research			272,209	–
Research and Training in Complementary and Integrative Health	93.213		234,129	–
Research on Healthcare Costs, Quality and Outcomes	93.226		221,630	–
Pass Through-University of California Los Angeles	93.226	1R01HS025394-01	64,580	–
Total Research on Healthcare Costs, Quality and Outcomes			286,210	–
Special Diabetes Program for Indians Diabetes Prevention and Treatment Projects				
Pass Through-Icahn School of Medicine at Mount Sinai	93.237	P50HL112324	(2,721)	–

See notes to Schedule of Expenditures of Federal Awards

Cedars-Sinai Health System

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2018

Federal Grantor/Program or Cluster Title/Pass Through Grantor	CFDA No.	Pass Through Grantor Identifying No.	Federal Expenditures	Expenditures to Subrecipients
Mental Health Research Grants	93.242		$ 308,291	$ –
Pass Through-University of North Carolina	93.242	4R33MH104330	91,041	–
Pass Through-University of North Carolina	93.242	U01MH070890	14,496	–
Pass Through-University of North Carolina	93.242	1R01MH111944-01A1	50,003	–
Pass Through-University of Washington	93.242	3UH3MH106338	8,747	–
Pass Through-California Institute of Technology	93.242	23A-1097962	155,476	–
Total Pass Through-Mental Health Research Grants			319,763	–
Total Mental Health Research Grants			628,054	–
Alcohol Research Programs	93.273		688,868	–
Pass Through-University of Southern California	93.273	P50 AA011999	80,360	–
Total Alcohol Research Programs			769,228	–
Drug Abuse and Addiction Research Programs	93.279		161,802	–
Pass Through-California Institute of Technology	93.279	R01DA040011	31,374	–
Pass Through-Indiana University	93.279	R42DA043391	66,187	–
Pass Through-University of North Carolina	93.279	1R01DA042988-01A1	122,279	–
Total Pass Through-Drug Abuse and Addiction Research Programs			219,840	–
Total Drug Abuse and Addiction Research Programs			381,642	–
Centers for Disease Control and Prevention: Investigations and Technical Assistance	93.283		297,205	–
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286		473,171	–
Minority Health and Health Disparities Research				
Pass Through-Ohio State University	93.307	R01MD007867	27,217	–
Trans-NIH Research Support				
Pass Through- University of California San Diego	93.310	1OT2OD024611-01	189,909	–
Pass Through- University of California San Diego	93.310	1OT2OD026552-01	107,095	–
Total Pass Through-Trans-NIH Research Support			297,004	–
Total Trans-NIH Research Support			297,004	–
National Center for Advancing Translational Sciences				
Pass Through-University of California Los Angeles	93.350	UL1 TR001881	1,759,102	–
Pass Through-Massachusetts Insitute of Technology	93.350	U24TR001951-02	56,332	–
Total Pass Through-National Center for Advancing Translational Sciences			1,815,434	–
Total National Center for Advancing Translational Sciences			1,815,434	–
Research Infrastructure Programs				
Pass Through-Jackson Laboratory	93.351	U54OD020351	20,835	–
Advance Education Nursing Traineeships				
Pass Through-University of California Los Angeles	93.358	KL2TR001882	92,888	–
Pass Through-University of California Los Angeles	93.358	UL1TR001881	28,569	–
Total Pass Through-Advance Education Nursing Traineeships			121,457	–
Total Advance Education Nursing Traineeships			121,457	–

See notes to Schedule of Expenditures of Federal Awards

Cedars-Sinai Health System

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2018

Federal Grantor/Program or Cluster Title/Pass Through Grantor	CFDA No.	Pass Through Grantor Identifying No.	Federal Expenditures	Expenditures to Subrecipients
National Center for Research Resources				
Pass Through-University of California Los Angeles	93.389	UL1RR033176	$ (236)	$ –
Cancer Cause and Prevention Research	93.393		4,230,272	1,514,047
Pass Through-Fred Hutchinson Cancer Research Center	93.393	R01 CA201407	51,576	–
Pass Through-University of Texas, MD Anderson Cancer Center	93.393	R01CA188943	32,467	–
Pass Through-Dana Farber Cancer Institute	93.393	R21 CA191725	38,464	–
Pass Through-Dana Farber Cancer Institute	93.393	R01CA204954	156,858	–
Pass Through-Memorial Sloan-Kettering Cancer Center	93.393	R01CA179115	53,676	–
Pass Through-University of California Los Angeles	93.393	P01CA163200	18,845	–
Pass Through-Van Andel Research Institute	93.393	R01CA190182	27,593	–
Pass Through-Washington University in St. Louis	93.393	N/A	57,913	–
Pass Through-University of Utah	93.393	1U01CA206110-01	468,780	–
Pass Through-University of South Wales	93.393	R01CA172404	340,940	–
Pass Through-Northwestern University	93.393	HHSN261201200035I	7,809	–
Pass Through-Moffitt Cancer & Research Institute	93.393	1R01CA207456	264,714	–
Pass Through-University of Southern California	93.393	1R01CA209798-01A1	7,851	–
Pass Through-University of Virginia	93.393	1R01CA211574-01A1	23,305	–
Total Pass Through-Cancer Cause and Prevention Research			1,550,791	–
Total Cancer Cause and Prevention Research			5,781,063	1,514,047
Cancer Detection and Diagnosis Research	93.394		3,215,076	221,000
Pass Through-Van Andel Research Institute	93.394	U24CA210969	192,011	–
Pass Through-University of California Los Angeles	93.394	U01CA198900	59,743	–
Pass Through-New York School of Medicine	93.394	U01CA214195	30,808	–
Total Pass Through-Cancer Detection and Diagnosis Research			282,562	–
Total Cancer Detection and Diagnosis Research			3,497,638	221,000
Cancer Treatment Research	93.395		1,835,355	–
Pass Through-Mayo Foundation for Medical Education	93.395	UG1CA189823	33,213	–
Pass Through-University of California Los Angeles	93.395	R01 CA160427	(760)	–
Pass Through-Brigham and Women Hospital	93.395	U10 CA076001	77,382	–
Pass Through-Children's Hospital Philadelphia	93.395	U10 CA098543	10,958	–
Pass Through-Childrens' Hospital Boston	93.395	1R21CA198722-01A1	39,983	–
Pass Through-Oregon Health Science University	93.395	U10 CA032102	56,303	–
Pass Through-NRG Oncology Foundation	93.395	U10 CA180868	10,991	–
Pass Through-John Wayne Cancer Institute	93.395	5R01CA189163-03	161,850	–
Pass Through-Cancer and Leukemia Group B	93.395	U10 CA31946	12,236	–
Total Pass Through-Cancer Treatment Research			402,156	–
Total Cancer Treatment Research			2,237,511	–
Cancer Biology Research	93.396		2,726,675	126,711
Cancer Centers Support Grants				
Pass Through-MD Anderson Cancer Center	93.397	5U54CA163191-06	76,786	–
Cancer Research Man Power	93.398		403,133	–

See notes to Schedule of Expenditures of Federal Awards

Cedars-Sinai Health System

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2018

Federal Grantor/Program or Cluster Title/Pass Through Grantor	CFDA No.	Pass Through Grantor Identifying No.	Federal Expenditures	Expenditures to Subrecipients
Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities				
Pass Through-California Department of Public Health	93.817	U3REP160550-01-00	$ 612,997	$ –
National Ebola Training and Education Center	93.825		20,041	–
Cardiovascular Diseases Research	93.837		15,636,606	–
Pass Through-Emory University	93.837	U01HL105561	138,015	–
Pass Through-University of California Los Angeles	93.837	P01 HL028481	135	–
Pass Through-University of Michigan	93.837	1R21HL140274-01	57,859	–
Pass Through-University of Michigan	93.837	HHSN268201100026C	7,505	–
Pass Through-Wake Forest University	93.837	R01HL111362	33,779	–
Pass Through-Vanderbuilt University Medical Center	93.837	1P01HL129941	460,482	–
Pass Through-New England Research Institute	93.837	U24HL135691	52,721	–
Pass Through-New England Research Institute	93.837	U10HL068270	(469)	–
Pass Through-Allina Health	93.837	UM1 HL087394	220,977	–
Pass Through-RTI International	93.837	U01 HL11991	19,328	–
Pass Through-Weill Cornell Medical College	93.837	R01HL118019	47,354	–
Pass Through-Weill Cornell Medical College	93.837	R01HL111141	28,592	–
Pass Through-Johns Hopkins University School of Medicine	93.837	P01 HL0107153	129,920	–
Pass Through-Johns Hopkins University School of Medicine	93.837	UO1DK085689	1,793	–
Pass Through-Johns Hopkins University School of Medicine	93.837	R35HL135827	73,985	–
Pass Through-Columbia University Medical Center	93.837	RO1HL130500	89,445	–
Pass Through-University of Texas, Arlington	93.837	1R01HL136601-01A1	23,875	–
Pass Through- Duke University	93.837	U10HL084904	12,432	–
Pass Through-University of Miami	93.837	1R01HL137355	43,773	–
Total Pass Through-Cardiovascular Diseases Research			1,441,501	–
Total Cardiovascular Diseases Research			17,078,107	–
Lung Diseases Research	93.838		2,102,485	–
Pass Through-Duke University	93.838	U01 HL11018	16,893	–
Pass Through-Yale University	93.838	1R01HL138540-01	151,987	–
Pass Through-Cincinnati Children's Hospital Medical Center	93.838	U01 HL122642	42,106	–
Total Pass Through-Lung Diseases Research			210,986	–
Total Lung Diseases Research			2,313,471	–
Arthritis, Musculoskeletal and Skin Diseases Research	93.846		703,304	–
Pass Through-Columbia University Medical Center	93.846	R01AR050026	114,902	–
Pass Through-University of Texas-Houston	93.846	P01AR052915	17,209	–
Pass Through-University of Pennsylvania	93.846	U54AR057319	5,400	–
Pass Through-Pennsylvania State University	93.846	U34AR067392	(20)	–
Pass Through-Pennsylvania State University	93.846	1U01AR071077-01	81,269	–
Pass Through-University of Colorado	93.846	UH2AR067681	115,821	–
Pass Through-University of Iowa	93.846	2R01AR059703	13,049	–
Total Pass Through-Arthritis, Musculoskeletal and Skin Diseases Research			347,630	–
Total Arthritis, Musculoskeletal and Skin Diseases Research			1,050,934	–

See notes to Schedule of Expenditures of Federal Awards

Cedars-Sinai Health System

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2018

Federal Grantor/Program or Cluster Title/Pass Through Grantor	CFDA No.	Pass Through Grantor Identifying No.	Federal Expenditures	Expenditures to Subrecipients
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847		$ 7,369,122	$ 317,690
Pass Through-University of California San Diego	93.847	P30 DK063491	88,639	–
Pass Through-University of California Los Angeles	93.847	P01DK098108	309,807	–
Pass Through-Duke University	93.847	R01 DK098382	41,394	–
Pass Through-Childrens Hospital Boston	93.847	R01DK104641	32,881	–
Pass Through-California Institute of Technology	93.847	5R01MH100556	24,252	–
Pass Through-MD Anderson Cancer Center	93.847	U01DK108328-02S1	8,413	–
Pass Through-University of Washington, Seattle	93.847	R01DK088762	10,028	–
Pass Through-University of Minnesota	93.847	5U01DK106786-03	87,539	–
Total Pass Through-Diabetes, Digestive, and Kidney Diseases Extramural Research			602,953	–
Total Diabetes, Digestive, and Kidney Diseases Extramural Research			7,972,075	317,690
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853		3,841,231	979,009
Pass Through-University of California Los Angeles	93.853	U01NS098961	237,992	–
Pass Through-University of California Los Angeles	93.853	R01 NS077706	(2,024)	–
Pass Through-University of California Irvine	93.853	U54NS091046	570,658	–
Pass Through-Partners Healthcare	93.853	U01NS088312	65,571	–
Pass Through-Children's Hospital Philadelphia	93.853	R01NS096746	14,112	–
Pass Through-EMMES	93.853	U01NS026835	11,569	–
Pass Through-Mayo Clinic Rochester	93.853	P5001NS080168	10,181	–
Total Pass Through-Extramural Research Programs in the Neurosciences and Neurological Disorders			908,059	–
Total Extramural Research Programs in the Neurosciences and Neurological Disorders			4,749,290	979,009
Allergy and Infectious Diseases Research	93.855		5,523,507	–
Pass Through-Brigham and Womens Hospital	93.855	U01 AI063623	1,500	–
Pass Through-University of California San Francisco	93.855	U01AI113362	93,492	–
Pass Through-University of California San Francisco	93.855	UM1AI110498-03	10,687	–
Pass Through-Massachusetts General Hospital	93.855	R34AI125058	56,758	–
Total Pass Through-Allergy and Infectious Diseases Research			162,437	–
Total Allergy and Infectious Diseases Research			5,685,944	–
Biomedical Research and Research Training	93.859		518,567	–
Pass Through-Thomas Jefferson University	93.859	R01 GM106047	15,939	–
Total Biomedical Research and Research Training			534,506	–
Child Health and Human Development Extramural Research	93.865		925,113	–
Pass Through-University of California Los Angeles	93.865	R21HD084204	115,712	–
Pass Through-University of Colorado Springs	93.865	R01 HD073491	138,302	–
Total Pass Through-Child Health and Human Development Extramural Research			254,014	–
Total Child Health and Human Development Extramural Research			1,179,127	–
Aging Research	93.866		685,330	–
Vision Research	93.867		3,297,485	–

See notes to Schedule of Expenditures of Federal Awards

Cedars-Sinai Health System

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2018

Federal Grantor/Program or Cluster Title/Pass Through Grantor	CFDA No.	Pass Through Grantor Identifying No.	Federal Expenditures	Expenditures to Subrecipients
National Cancer Institute	93.RD		$ 135,541	$ –
Pass Through-Cleveland Clinic	93.RD	HHSN268200700036C	4	–
Pass Through-Northwestern University	93.RD	HHSN2612012000351	56,994	–
Pass Through-Northwestern University	93.RD	SP001604060045298	61,564	–
Pass Through-Northwestern University	93.RD	SP001604060045323	101,030	–
Pass Through-University of Massachusetts Medical School	93.RD	HHSN261201500029C	22,380	–
Pass Through-Suburban Hospital	93.RD	HHSN268201300001C	(338)	–
Pass Through-University of Arizona	93.RD	HHSN2612012000311	19,710	–
Total Pass Through-National Cancer Institute			261,344	–
Total National Cancer Institute			396,885	–
National Academy of Science & USAID	98.000	AID-263-A-15-00002	48,405	–
Total Research and Development Cluster			75,730,756	3,213,999
National Bioterrorism Hospital Preparedness Program				
Pass Through-County of Los Angeles	93.889	H-705557	201,133	–
Pass Through-County of Los Angeles	93.889	H-707432	42,781	–
Total National Bioterrorism Hospital Preparedness Program			243,914	–
Total Department of Health and Human Services			**66,485,351**	**3,158,457**
Total Expenditures of Federal Awards			**$ 75,974,670**	**$ 3,213,999**

See notes to Schedule of Expenditures of Federal Awards

Notes to Schedule of Expenditures of Federal Awards

Year Ended June 30, 2018

1. The accompanying schedule of expenditures of federal awards (the Schedule) includes the federal grant activity of Cedars-Sinai Health System and is presented on the accrual basis of accounting. The information on this schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (the Uniform Guidance). Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the consolidated financial statements of Cedars-Sinai Health System. For purposes of the Schedule, federal awards include any assistance provided by a federal agency directly or indirectly in the form of grants, contracts, cooperative agreements, loan and loan guarantees, or other non-cash assistance.

   Direct and indirect costs are charged to awards in accordance with cost principles contained in the United States Department of Health and Human Services Cost Principles for Hospitals at 45 CFR Part 75 Appendix IX for Federal awards subject to the requirements of the Uniform Guidance, and at 45 CFR Part 74 Appendix E for Federal awards funded prior to the Uniform guidance effective date. Under these cost principles, certain types of expenditures are not allowable or are limited as to reimbursement. The Uniform Guidance provides for a 10% de minimis indirect cost rate election; however, Cedars-Sinai Health System did not make this election and uses a negotiated indirect cost rate.

   The Schedule includes Federal awards subject to the requirements of the Uniform Guidance, as well as Federal awards that were funded prior to the Uniform Guidance effective date of December 26, 2014.

2. Federal Expenditures of $75,974,670 are reported in Cedars-Sinai Health System's consolidated financial statements for the fiscal year ended June 30, 2018, as net assets released from restrictions. Negative amounts shown on the Schedule represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years.

Schedule Required by the Uniform Guidance

Cedars-Sinai Health System

Schedule of Findings and Questioned Costs

For the Year Ended June 30, 2018

Section I—Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	**Unmodified**	
Internal control over financial reporting:		
Material weakness(es) identified?	______ **yes**	X **no**
Significant deficiency(ies) identified?	______ **yes**	X **none reported**
Noncompliance material to financial statements noted?	______ **yes**	X **no**

Federal Awards

Internal control over major federal programs:		
Material weakness(es) identified?	______ **yes**	X **no**
Significant deficiency(ies) identified?	______ **yes**	X **none reported**
Type of auditor's report issued on compliance for major federal programs:	**Unmodified**	
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	______ **yes**	X **no**

Section I—Summary of Auditor's Results (continued)

Identification of major federal programs:

CFDA number(s)	Name of federal program or cluster
Various CFDA numbers, as reported in Schedule of Expenditures of Federal Awards	Research and Development Cluster

Dollar threshold used to distinguish between Type A and Type B programs:	$ 2,279,240
Auditee qualified as low-risk auditee?	X **yes** ______ **no**

Section II—Financial Statement Findings

No such items were identified.

Section III—Federal Award Findings and Questioned Costs

No such items were identified.

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