**PRELIMINARY OFFERING MEMORANDUM DATED MARCH 3, 2016**

**NEW ISSUE – FULL BOOK-ENTRY**

**RATINGS: Moody's: ____**
**S&P: ____**
**(See "RATINGS" herein)**

# $300,000,000*
# MAYO CLINIC
## _____% Taxable Bonds, Series 2016

**Price: ____%**

**CUSIP No.: _____†**

**Dated: Date of Delivery**

**Due: November 15, 20__**

The above-described bonds (the "Bonds") are being issued in fully registered form in denominations of $1,000 and integral multiples thereof, and when issued, will be registered in the name of Cede & Co., as registered owner and nominee for The Depository Trust Company, New York, New York ("DTC"). Interest from the date of delivery of the Bonds is payable on each May 15 and November 15, commencing November 15, 2016. Ownership by the Beneficial Owners of the Bonds will be evidenced by book-entry only and purchasers of the Bonds will not receive physical delivery of the bond certificates. So long as Cede & Co., as nominee of DTC, is the registered owner of the Bonds, all references to the Bondholders or Registered Owners of the Bonds will mean Cede & Co. and not the Beneficial Owners of the Bonds. See "THE BONDS – Securities Depository."

**The Bonds are subject to optional redemption at the Make-Whole Redemption Price prior to maturity as described herein. See "THE BONDS – Redemption."**

The Bonds are being issued by Mayo Clinic pursuant to an Indenture of Trust (the "Indenture") between Mayo Clinic and Wells Fargo Bank, National Association, as trustee (the "Trustee"). The proceeds of the sale of the Bonds will be used by Mayo Clinic for its general corporate purposes, including payment of costs of issuing the Bonds.

The Bonds are general, unsecured obligations of Mayo Clinic.

MAYO CLINIC

**Interest on and gain, if any, on the sale of the Bonds are not excludable from gross income for federal, state or local income tax purposes. See "CERTAIN UNITED STATES INCOME TAX CONSIDERATIONS" herein.**

The Bonds are offered by the Underwriters when, as and if issued and received by the Underwriters, subject to prior sale, withdrawal or modifications of the offer without any notice, and to the approval of legality by Dorsey & Whitney LLP, Minneapolis, Minnesota, Bond Counsel for Mayo Clinic. Certain legal matters will be passed upon for Mayo Clinic by the Legal Department of Mayo Clinic and for the Underwriters by their counsel, Ballard Spahr LLP, Philadelphia, Pennsylvania. The Bonds in definitive form are expected to be available for delivery to the Underwriters via DTC in New York, New York on or about March __, 2016.

**BofA Merrill Lynch** **Wells Fargo Securities**

The date of this Offering Memorandum is March __, 2016.

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* Preliminary, subject to change.

† The CUSIP number on the cover page of this Offering Memorandum is copyrighted by the American Bankers Association. CUSIP data herein is provided by Standard & Poor's CUSIP Service Bureau, a division of The McGraw-Hill Companies, Inc., and none of the Mayo Clinic or the Underwriters takes any responsibility for the accuracy thereof. These data are not intended to create a database and do not serve in any way as a substitute for the CUSIP Service Bureau.

No dealer, broker, salesman or other person has been authorized by Mayo Clinic or the Underwriters to give any information or to make any representations with respect to this offering, other than those contained in this Offering Memorandum, and if given or made, such other information or representations must not be relied upon as having been authorized by any of the foregoing. This Offering Memorandum does not constitute an offer to sell or the solicitation of an offer to buy, and there shall be no sale of the Bonds by any person in any state in which it is unlawful for such person to make such offer, solicitation or sale. The information set forth herein has been obtained from Mayo Clinic, its affiliates and other sources which are believed to be reliable, but is not guaranteed as to accuracy or completeness by, and is not to be construed as a representation of, the Underwriters. The information and expressions of opinions contained herein are subject to change without notice and neither the delivery of this Offering Memorandum nor any sale made hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of Mayo Clinic (or any of its affiliates) or in any of the information set forth herein since the date hereof. This offering of the Bonds is made only by means of this entire Offing Memorandum.

IN CONNECTION WITH THIS OFFERING, THE UNDERWRITERS MAY OVERALLOT OR EFFECT TRANSACTIONS WHICH STABILIZE OR MAINTAIN THE MARKET PRICE OF THE BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

**The Bonds have not been registered with the Securities and Exchange Commission ("SEC") under the Securities Act of 1933, as amended, in reliance upon the exemption contained in Section 3(a)(4) of such Act; and the Indenture has not been qualified under the Trust Indenture Act of 1939, as amended, in reliance upon certain exemptions contained in such Act. In making an investment decision, investors must rely upon their own examination of the Bonds and the security therefor, including an analysis of the risks involved. Prospective investors should not construe the contents of this Offering Memorandum as legal, tax or investment advice. The Bonds have not been recommended by any federal or state securities commission or regulatory authority. The registration, qualification or exemption of the Bonds in accordance with applicable provisions of securities laws of the various jurisdictions in which the Bonds have been registered, qualified or exempted cannot be regarded as a recommendation thereof. Neither such jurisdictions nor any of their agencies have passed upon the merits of the Bonds or the adequacy, accuracy or completeness of this Offering Memorandum. Any representation to the contrary may be criminal offense.**

**THE BONDS HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SEC OR WITH THE SECURITIES COMMISSION OR ANY REGULATORY AUTHORITY OF ANY STATE, NOR HAS THE SEC OR ANY STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFERING MEMORANDUM. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.**

This Offering Memorandum contains words such as "believe," "plan," "expect," "anticipate" and similar expressions that constitute forward-looking statements. Specifically, forward-looking statements in this Offering Memorandum include, without limitation, statements relating to: the outlook for patient care services at Mayo Clinic's clinical sites and hospitals; Mayo Clinic's diversification activities; its development program and investment programs; its plans with respect to pensions and benefits; and its other future plans and anticipated expenditures.

By their nature, such forward-looking statements involve risks and uncertainties because they relate to events and depend on circumstances that will occur in the future. These risks and uncertainties include, without limitation: impacts of the Patient Protection Affordable Care Act; changes in Medicare, Medicaid and other third-party health care reimbursement programs; changes in the regulatory environment for providers of health care, research and education; changes in the rules and regulations governing activities of nonprofit charitable organizations; competition; inflation, interest rate changes or other adverse economic conditions; the availability of nurses and other health care, research and education employees; investment returns on endowments and pension funds; and changes in the availability of the funding for medical research activities and medical education. For further information, see "INVESTMENT CONSIDERATIONS." Should one or more of these uncertainties or risks materialize, actual results may vary materially from those anticipated. Accordingly, readers are cautioned not to place undue reliance on forward-looking statements.

The Underwriters have provided the following sentence for inclusion in the Offering Memorandum: The Underwriters have reviewed the information in this Offering Memorandum in accordance with, and as part of, their responsibilities to investors under the federal securities law as applied to the facts and circumstances of this transaction, but the Underwriters do not guarantee the accuracy or completeness of such information.

Any references to internet websites in this Offering Memorandum are shown for reference and convenience only; unless explicitly stated to the contrary, the information contained within the websites and any links contained within those websites are not incorporated herein by reference and do not constitute a part of this Offering Memorandum.

## NOTICE TO INVESTORS

### Notice to Investors in the European Economic Area

In relation to each Member State of the European Economic Area which has implemented the Prospectus Directive (each, a "Relevant Member State"), an offer to the public of any Bonds may not be made in that Relevant member State, except that an offer to the public in that Relevant Member State of Bonds may be made at any time under the following exemptions under the Prospectus Directive, if they have been implemented in that Relevant Member State:

(a) to legal entities which are qualified investors as defined in the Prospectus Directive;

(b) to fewer than 100, or, if the Relevant Member State has implemented the relevant provisions of the 2010 PD Amending Directive, 150, natural or legal persons (other than qualified investors as defined in the Prospectus Directive), as permitted under the Prospectus Directive, subject to obtaining the prior consent of the Underwriters for any such offer; or

(c) in any other circumstances falling within Article 3(2) of the Prospectus Directive;

Provided that no such offer of any Bonds shall result in a requirement for the publication of a prospectus pursuant to Article 3 of the Prospectus Directive.

For the purposes of this provisions, the expression an "offer to the public" in relation to any Bonds in any Relevant Member State means the communication in any form and by any means of sufficient information on the terms of the offer and any Bonds to be offered so as to enable an investor to decide to purchase any Bonds, as the same may be varied in that Relevant Member State by any measure implementing the Prospectus Directive in that Relevant Member State, the expression "Prospectus Directive" means Directive 2003/71/EC (and amendments thereto, including the 2010 PD Amending Directive, to the extent implemented in the Relevant Member State), and includes any relevant implementing measure in the Relevant Member State, and the expression "2010 PD Amending Directive" means Directive 2010/73/EU.

### Notice to Investors in the United Kingdom

This Offering Memorandum is only being distributed to and is only directed at (i) persons who are outside the United Kingdom or (ii) investment professionals falling within Article 19(5) of the Financial Services and Markets Act 2000 (Financial Promotion) Order 2005, as amended (the "Order") or (iii) high net worth companies, and other persons to whom it may lawfully be communicated, falling within Article 49(2)(a) to (d) of the Order (all such persons together being referred to a "relevant persons"). The Bonds are only available to, and any invitation, offer or agreement to subscribe, purchase or otherwise acquire such Bonds will be engaged in only with, relevant persons. Any person who is not a relevant person should not act or rely on this Offering Memorandum or any of its contents.

Each Underwriter has represented and agreed that:

(a) it has only communicated or caused to be communicated and will only communicate or cause to be communicated an invitation or inducement to engage in investment activity (within the meaning of Section 21 of the FSMA) received by it in connection with the issue or sale of the Bonds in circumstances in which Section 21(1) of the FSMA does not apply to the Underwriters; and

(b) it has complied and will comply with all applicable provisions of the FSMA with respect to anything done by it in relation to the Bonds in, from or otherwise involving the United Kingdom.

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## SUMMARY OF THE OFFERING

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|---|---|
| **Issuer** | Mayo Clinic |
| **Securities Offered** | $300,000,000* _____% Taxable Bonds, Series 2016, due November 15, 20__. |
| **Payment Obligations** | The Bonds are general, unsecured obligations of Mayo Clinic, and are not secured by a lien on or security interest in any assets, property or revenues of Mayo Clinic or any of its affiliates. However, Mayo Clinic agrees in the Indenture that it will not permit any "Liens" other than "Permitted Encumbrances" to be placed on any of its property or on any of the property of its direct or indirect affiliates and subsidiaries, unless that Lien is also granted to secure the Bonds. See "SECURITY FOR THE BONDS" herein and "Particular Covenants – Negative Pledge" in APPENDIX C. |
| **Interest Accrual Date** | Interest will accrue from the Date of Issuance. |
| **Interest Payment Dates** | May 15 and November 15 of each year, commencing November 15, 2016. |
| **Redemption** | The Bonds are subject to optional redemption at the Make-Whole Redemption Price as discussed more fully herein. See THE BONDS – Optional Redemption." |
| **Date of Issuance** | March __, 2016. |
| **Authorized Denominations** | $1,000 and any integral multiple thereof. |
| **Form and Depository** | The Bonds will be delivered solely in registered form under a global book-entry system through the facilities of DTC. |
| **Use of Proceeds** | Mayo Clinic will use the net proceeds of the Bonds for general corporate purposes. See "USE OF PROCEEDS" herein. |
| **Ratings** | Moody's: "___"; S&P: "__" |

THE BONDS HAVE NOT BEEN REGISTERED WITH THE SECURITIES AND EXCHANGE COMMISSION ("SEC") UNDER THE SECURITIES ACT OF 1933, AS AMENDED, IN RELIANCE UPON THE EXEMPTION CONTAINED IN SECTION 3(A)(4) OF SUCH ACT; AND THE INDENTURE HAS NOT BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON CERTAIN EXEMPTIONS CONTAINED IN SUCH ACT.

THE BONDS HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SEC OR WITH THE SECURITIES COMMISSION OR ANY REGULATORY AUTHORITY OF ANY STATE, NOR HAS THE SEC OR ANY STATE SECURITIES COMMISSION OR REGULATORY AUTHORITY, INCLUDING WITHOUT LIMITATION THE MINNESOTA DEPARTMENT OF COMMERCE, INSURANCE AND REGISTRATION DIVISION, PASSED UPON THE ACCURACY OR ADEQUACY OF THIS OFFERING MEMORANDUM. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

* Preliminary, subject to change.

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**OFFERING MEMORANDUM**

**Relating to**

**$300,000,000*
MAYO CLINIC
_____% Taxable Bonds, Series 2016**

## INTRODUCTORY STATEMENT

The purpose of this Offering Memorandum, including the cover page and the appendices, is to set forth certain information with respect to Mayo Clinic and its affiliates, and the above-referenced bonds (the "Bonds") of Mayo Clinic.

**Mayo Clinic**. Mayo Clinic is a Minnesota nonprofit corporation headquartered in Rochester, Minnesota which, itself and through its affiliates and subsidiary organizations, provides comprehensive medical care, education in clinical medicine and the medical sciences and extensive programs in medical research. Mayo Clinic is an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and is not a private foundation described in Section 509(a) of the Code. Mayo Clinic is organized and operated exclusively for educational and charitable purposes and not for pecuniary profit; and no part of the net earnings of Mayo Clinic inures to the benefit of any person, private stockholder or individual. Mayo Clinic is the direct or indirect corporate parent of corporations that own and/or operate health care facilities in Minnesota, Florida, Wisconsin, Iowa, Arizona and Georgia. Information with respect to Mayo Clinic, its affiliates and their operations is set forth in Appendix A.

**The Bonds**. Mayo Clinic is issuing the Bonds pursuant to an Indenture of Trust dated as of March 1, 2016 (as so amended and supplemented, the "Indenture") between Mayo Clinic and Wells Fargo Bank, National Association, as trustee (the "Trustee"). Interest from the date of delivery of the Bonds is payable on each May 15 and November 15, commencing November 15, 2016.

The Bonds will be issued as fully registered bonds without coupons in denominations of $1,000 or integral multiples thereof. The Bonds will have the final maturity date and will bear interest at the rate set forth on the front cover of this Offering Memorandum. The Bonds are subject to redemption prior to maturity. See "THE BONDS."

See Appendix C for a summary of certain provisions of the Indenture. Certain capitalized terms used in this Offering Memorandum are defined in Appendix C. The descriptions and summaries of various documents set forth in this Offering Memorandum (including the appendices) do not purport to be comprehensive or definitive and reference is made to each such document for complete details of all terms and conditions. All statements are qualified in their entirety by the terms of each such document.

* Preliminary, subject to change.

Copies of the Indenture are available for inspection at the corporate trust office of Wells Fargo Bank, National Association in Minneapolis, Minnesota.

**Security**. The Bonds are general, unsecured obligations of Mayo Clinic, and are not secured by a lien on or security interest in any assets, property or revenues of Mayo Clinic or any of its affiliates. However, Mayo Clinic agrees in the Indenture that it will not permit any "Liens" other than "Permitted Encumbrances" to be placed on any of its property or on any of the property of its direct or indirect affiliates and subsidiaries, unless that Lien is also granted to secure the Bonds. See "SECURITY FOR THE BONDS" and "OUTSTANDING INDEBTEDNESS."

The audited Consolidated Financial Report of Mayo Clinic as of December 31, 2015 and 2014, and for the years then ended, is set forth in Appendix B. The entities included in Mayo Clinic's Consolidated Financial Report include both nonprofit and for profit corporations, all of which are direct or indirect affiliates or subsidiaries of Mayo Clinic. Consequently, Mayo Clinic currently has the ability (directly or indirectly) to appoint and dismiss a majority of the members of the governing bodies of each of its direct or indirect affiliates or subsidiaries, and has reserved the right to approve certain actions of such entities, including the incurrence of significant amounts of indebtedness, the transfer of significant amounts of assets, the encumbrance of property, mergers or similar types of corporate reorganizations. However, neither the Indenture nor any other agreement executed in connection with the Bonds or for the benefit of the Bondholders (a) limits Mayo Clinic's ability to permit any of its subsidiaries to incur debt, transfer assets or undertake a corporate reorganization such as a merger, or (b) requires Mayo Clinic or its subsidiaries to pass any financial tests in connection with incurring debt, transferring assets or undertaking a corporation reorganization such as a merger. See "Particular Covenants – Merger or Consolidation; Sale of Assets" in Appendix C. See "Corporate Organization" in Appendix A for a description of Mayo Clinic and certain of its affiliates and subsidiaries, as well as a chart showing the current organizational relationship between Mayo Clinic and certain of its affiliates.

**Use of Proceeds**. The proceeds of the Bonds, together with other available moneys, are being used for eligible corporate purposes of Mayo Clinic, including the costs of issuing the Bonds. See "USE OF PROCEEDS."

**Risks; Other Matters**. There are risks associated with a purchase of the Bonds. See "INVESTMENT CONSIDERATIONS" for a description of certain of these risks.

## THE BONDS

### General

The Bonds will be dated their date of delivery and will mature on the date and bear interest at the rate set forth on the front cover page of this Offering Memorandum. The Bonds are being issued in fully registered form, without coupons, in denominations of $1,000 or any integral multiple thereof. Interest on the Bonds is payable on each May 15 and November 15, commencing November 15, 2016 (each, an "Interest Payment Date"), and will be computed on the basis of a 360-day year consisting of twelve 30-day months. The Bonds are subject to redemption prior to maturity as described herein.

While the Bonds are book-entry bonds, payment of the principal of, premium, if any, and interest on any Bond will be made by the Trustee to DTC, to the account of Cede & Co, as provided in the Letters of Representation. See "– Book-Entry System" below. In the event the Bonds are no longer book-entry bonds, principal of and premium, if any, on the Bonds will be payable at the designated corporate trust office of the Trustee, and interest on the Bonds will be payable by check mailed by the Trustee on the Interest Payment Date to the person whose name appears on the registration books of the Trustee as the

registered owner thereof at the close of business on the last day of the month immediately preceding that Interest Payment Date or on any date established by the Trustee as a special record date for the payment of defaulted interest on the Bonds (each such date is a "Record Date" for the Bonds).

**Redemption**

**Optional Redemption**. The Bonds are redeemable prior to maturity at the written direction of Mayo Clinic, in whole or in part on any Business Day, at the Make-Whole Redemption Price. Mayo Clinic will calculate the Make-Whole Redemption Price.

"Make-Whole Redemption Price" is the greater of (1) 100% of the principal amount of the Bonds to be redeemed; and (2) the sum of the present value of the remaining scheduled payments of principal and interest to the maturity date of the Bonds to be redeemed, not including any portion of those payments of interest accrued and unpaid as of the date on which the Bonds are to be redeemed, discounted to the date on which the Bonds are to be redeemed on a semiannual basis assuming a 360-day year consisting of twelve 30-day months at the adjusted Treasury Rate plus ___ basis points, plus in each case accrued and unpaid interest on the Bonds to be redeemed on the redemption date.

"Treasury Rate" means, as of any redemption date, the yield to maturity as of such redemption date of United States Treasury securities with a constant maturity (as compiled and published in the most recent Federal Reserve Statistical Release H.15 (519) that has become publicly available at least two Business Days prior to the redemption date (excluding inflation indexed securities) or, if such Statistical Release is no longer published, any publicly available source of similar market data) most nearly equal to the period from the redemption date to the maturity date of the Bond to be redeemed; provided, however, that if the period from the redemption date to such maturity date is less than one year, the weekly average yield on actually traded United States Treasury securities adjusted to a constant maturity of one year will be used.

**Mandatory Sinking Fund Redemption**. The Bonds are subject to mandatory redemption and will be redeemed on November 15 in the years and in the principal amounts set forth below, at a redemption price equal to 100% of the principal amount of such Bonds to be so redeemed, without premium, plus accrued interest to the redemption date.

| Year | Amount |
|---|---|
| 20__ | $ |
| 20__ | |
| 20__ | |
| 20__† | |

† Final maturity

**Partial Redemption**. Whenever provision is made in the Indenture for the redemption of less than all of the Bonds of a maturity, the Trustee is required to select the Bonds to be redeemed from all Bonds subject to redemption, by lot in any manner that is customary in the industry.

**Notices of Redemption**. Notice of redemption will be mailed by the Trustee by first class mail, not fewer than 20 days prior to the redemption date, to the respective Holders of any Bonds designated for redemption at their addresses appearing on the bond registration books of the Trustee. If the Bonds are no longer held by the Securities Depository or its successor or substitute, the Trustee also is required to give notice of redemption by overnight mail to such securities depositories and/or securities information

services as shall be designated in a certificate of Mayo Clinic. Each notice of redemption is required to state the date of such notice, the date of issue of the Bonds, the redemption date, the Redemption Price, the place or places of redemption (including the name and appropriate address or addresses of the Trustee), the maturity (including CUSIP number, if any), and, in the case of Bonds to be redeemed in part only, the portion of the principal amount thereof to be redeemed. Each such notice also is required to state that on said date there will become due and payable on each of said Bonds the redemption price thereof or of said specified portion of the principal amount thereof in the case of a Bond to be redeemed in part only, together with interest accrued thereon to the redemption date, and that from and after such redemption date interest thereon will cease to accrue, and shall require that such Bonds be then surrendered.

Failure by the Trustee to give notice to any one or more of the securities information services or depositories designated by Mayo Clinic, or the insufficiency of any such notice will not affect the sufficiency of the proceedings for redemption. Failure by the Trustee to mail notice of redemption to any one or more of the respective Holders of any Bonds designated for redemption will not affect the sufficiency of the proceedings for redemption with respect to the Holders to whom such notice was mailed.

Mayo Clinic may instruct the Trustee to provide conditional notice of redemption, which may be conditioned upon the receipt of moneys or any other event. Additionally, any redemption notice given may be rescinded by written notice given to the Trustee by Mayo Clinic no later than five Business Days prior to the date specified for redemption. The Trustee will give notice of such rescission, as soon thereafter as practicable, in the same manner, to the same Persons, as notice of such redemption was given.

**Effect of Redemption**. Notice of redemption having been duly given, and moneys for payment of the redemption price of, together with interest accrued to the date fixed for redemption of the Bonds (or portion thereof) so called for redemption being held by the Trustee, on the date fixed for redemption designated in such notice, the Bonds (or portion thereof) so called for redemption will become due and payable at the Redemption Price specified in such notice and interest accrued thereon to the date fixed for redemption, interest on the Bonds so called for redemption will cease to accrue, said Bonds (or portion thereof) will cease to be entitled to any benefit or security under this Indenture, and the Holders of said Bonds will have no rights in respect thereof except to receive payment of the Redemption Price and accrued interest to the date fixed for redemption from funds held by the Trustee for such payment.

The Indenture provides that the Bonds may be paid or discharged in any of the following ways:

(1) by paying or (causing to be paid) the principal or Redemption Price of and interest on all Bonds Outstanding when the same becomes due and payable;

(2) by delivering to the Trustee, for cancellation, all Bonds then Outstanding; and

(3) by depositing with the Trustee, in trust, at or before maturity, moneys or eligible Investment Securities in the necessary amount to pay when due or redeem all Bonds then Outstanding.

The Indenture provides that any deposit described in clause (3) above must consist of lawful money of the United States and/or Investment Securities described in clause (1) of the definition thereof, which are non-callable by the holder prior to maturity, the maturing principal of and interest on which will be sufficient to pay the principal or Redemption Price of and interest on the Bonds when due. See the definition of "Investment Securities" in APPENDIX C.

**Registration and Transfers**

Any Bond may be transferred upon the books of the Trustee by the Person in whose name it is registered, in person or by its duly authorized attorney, upon surrender of such Bond for cancellation, accompanied by delivery of a written instrument of transfer, duly executed in a form approved by the Trustee. Bonds may be exchanged at the Designated Office of the Trustee for a like aggregate principal amount of Bonds. The Trustee may require the Bondholder requesting such transfer or exchange to pay any tax or other governmental charge required to be paid with respect to such transfer or exchange, and the Trustee also may require the Bondholder requesting such transfer or exchange to pay a reasonable sum to cover any expenses incurred by Mayo Clinic in connection with such transfer or exchange. The Trustee is not required to transfer or exchange (i) any Bond during the 15 days next preceding the selection of Bonds for redemption or (ii) any Bond called for redemption.

**Book-Entry System**

The information contained in this section concerning DTC and DTC's book-entry system and in Appendix E has been obtained from sources that Mayo Clinic believes to be reliable, but neither Mayo Clinic nor the Underwriters take any responsibility for the accuracy thereof.

SO LONG AS CEDE & CO. IS THE REGISTERED OWNER OF THE BONDS, AS NOMINEE OF DTC, REFERENCES HEREIN TO THE BONDHOLDERS OR REGISTERED OWNERS OF THE BONDS MEAN CEDE & CO. AND SHALL NOT MEAN THE BENEFICIAL OWNERS OF THE BONDS.

**General**. DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered bonds registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued for the Bonds, in the amount of the principal amount of the Bonds, and will be deposited with DTC. Purchasers may own beneficial ownership interests in the Bonds in the United States through DTC and in Europe through Clearstream or Euroclear.

DTC, the world's largest depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million U.S. and non-U.S. equity issues, corporate and municipal debt issues and money market instruments from over 100 countries that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions, in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts, thereby eliminating the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants," and together with Direct Participants, "Participants"). The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each Bond ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase; Beneficial Owners are expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's procedures. Under its usual procedures, DTC mails an Omnibus Proxy to Mayo Clinic as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Payments of principal, redemption price and interest on the Bonds will be made to Cede & Co. or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts, upon DTC's receipt of funds and corresponding detail information from Mayo Clinic or the Trustee, on the payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC, nor its nominee, the Trustee or Mayo Clinic, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal, redemption price and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of Mayo Clinic or the Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to Mayo Clinic or the Trustee. Under such circumstances, in the event that a successor securities depository is not obtained, such Bond certificates are required to be printed and delivered. Mayo Clinic, in its sole discretion and without the consent of any other person, may terminate the services of DTC with respect to the Bonds if Mayo Clinic determines that (i) DTC is

unable to discharge its responsibilities with respect to the Bonds, or (ii) a continuation of the requirement that all of the Outstanding Bonds be registered in the registration books kept by the Trustee in the name of Cede & Co., as nominee of DTC, is not in the best interests of the Beneficial Owners. In the event that no substitute securities depository is found by Mayo Clinic or restricted registration is no longer in effect, Bond certificates will be delivered. See "Certificated Bonds" below.

The information herein concerning DTC and DTC's book-entry system has been obtained from sources that Mayo Clinic and the Underwriters believe to be reliable, but Mayo Clinic and the Underwriters take no responsibility for the accuracy thereof.

Each person for whom a Participant acquires an interest in the Bonds, as nominee, may desire to make arrangements with such Participant to receive a credit balance in the records of such Participant, and may desire to make arrangements with such Participant to have all notices of redemption or other communications to DTC, which may affect such persons, to be forwarded in writing by such Participant and to have notification made of all interest payments. NEITHER MAYO CLINIC NOR THE TRUSTEE WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO SUCH PARTICIPANTS OR THE PERSONS FOR WHOM THEY ACT AS NOMINEES WITH RESPECT TO THE BONDS.

So long as Cede & Co. is the registered owner of the Bonds, as nominee for DTC, references herein to Bondholders or registered owners of the Bonds means Cede & Co., as aforesaid, and shall not mean the Beneficial Owners of the Bonds.

When reference is made to any action which is required or permitted to be taken by the Beneficial Owners, such reference shall only relate to those permitted to act (by statute, regulation or otherwise) on behalf of such Beneficial Owners for such purposes. When notices are given, they shall be sent by the Trustee to DTC only.

For every transfer and exchange of Bonds, the Beneficial Owner may be charged a sum sufficient to cover any tax, fee or other governmental charge that may be imposed in relation thereto.

NONE OF MAYO CLINIC, THE UNDERWRITERS AND THE TRUSTEE WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO DIRECT PARTICIPANTS, TO INDIRECT PARTICIPANTS, OR TO ANY BENEFICIAL OWNER WITH RESPECT TO (I) THE ACCURACY OF ANY RECORDS MAINTAINED BY DTC, ANY DIRECT PARTICIPANT, OR ANY INDIRECT PARTICIPANT; (II) ANY NOTICE THAT IS PERMITTED OR REQUIRED TO BE GIVEN TO THE OWNERS OF THE BONDS UNDER THE INDENTURE; (III) THE SELECTION BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY PERSON TO RECEIVE PAYMENT IN THE EVENT OF A PARTIAL REDEMPTION OF THE BONDS; (IV) THE PAYMENT BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY AMOUNT WITH RESPECT TO THE PRINCIPAL OR REDEMPTION PRICE, IF ANY, OR INTEREST DUE WITH RESPECT TO THE BONDS; (V) ANY CONSENT GIVEN OR OTHER ACTION TAKEN BY DTC AS THE OWNER OF THE BONDS; OR (VI) ANY OTHER MATTER.

**Certificated Bonds**. DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to Mayo Clinic or the Trustee. In addition, Mayo Clinic may determine that continuation of the system of book-entry transfers through DTC (or a successor securities depository) is not in the best interests of the Beneficial Owners. If for either reason the Book-Entry-Only system is discontinued, Bond certificates will be delivered as described in the Indenture and the Beneficial Owner, upon registration of certificates held in the Beneficial Owner's name, will become the Bondholder. Thereafter, the Bonds may be exchanged for an equal aggregate principal amount of the Bonds in other authorized denominations, upon surrender thereof at the designated

corporate trust office of the Trustee. The transfer of any Bond may be registered on the books maintained by the Trustee for such purpose only upon assignment in form satisfactory to the Trustee.

**Global Clearance Procedures**. See Appendix E for a description of global clearance procedures with respect to the Bonds.

## OUTSTANDING INDEBTEDNESS

Mayo Clinic currently is obligated to make debt service payments on several series of tax-exempt revenue bonds previously issued by the City of Rochester, Minnesota (the "Minnesota Bonds") for the benefit of Mayo Clinic and certain of its controlled affiliates. The "Minnesota Bonds" consist of:

- Health Care Facilities Revenue Bonds (Mayo Foundation), Series 2000A, Series 2000B and Series 2000C currently outstanding in the aggregate principal amount of $290,000,000 (the "2000 Minnesota Bonds")

- Health Care Facilities Revenue Bonds (Mayo Foundation) Series 2002A, Series 2002B and Series 2002C currently outstanding in the aggregate principal amount of $200,000,000 (the "2002 Minnesota Bonds")

- Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2006 currently outstanding in the aggregate principal amount of $75,000,000 (the "2006 Minnesota Bonds")[*]

- Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2008A, Series 2008B, Series 2008C, Series 2008D and Series 2008E currently outstanding in the aggregate principal amount of $330,000,000 (the "2008 Minnesota Bonds")

- Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2011A, Series 2011B and Series 2011C, currently outstanding in the aggregate principal amount of $285,000,000 (the "2011 Minnesota Bonds")

- Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2012, currently outstanding in the aggregate principal amount of $200,000,000 (the "2012 Minnesota Bonds")

- Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2014, currently outstanding in the aggregate principal amount of $120,000,000 (the "2014 Minnesota Bonds").

Mayo Clinic's other long-term indebtedness (collectively referred to as the "Term Loans") consists of taxable debt bearing interest at fixed rates as follows:

- $18,750,000 2.01% term loan from U.S. Bank National Association maturing on November 15, 2016

[*] Mayo Clinic currently expects to refund, for interest rate savings, the outstanding principal amount of the 2006 Minnesota Bonds through one or more series of tax-exempt bonds (the "2016 Tax-Exempt Bonds") to be issued on or around May 3, 2016 in an amount sufficient, together with other moneys available to Mayo Clinic, to redeem or pay off all of the outstanding 2006 Minnesota Bonds on May 15, 2016. At this point, however, no assurances can be given that the 2016 Tax-Exempt Bonds will be issued, or if so, when the refunding of any of the 2006 Minnesota Bonds will occur.

- $15,000,000 2.01% term loan from Wells Fargo Bank, National Association maturing on November 15, 2016

- $215,000,000 4.71% Senior Notes maturing on December 15, 2046

- $300,000,000 Mayo Clinic 3.774% Taxable Bonds, Series 2012B maturing on November 15, 2043

- $300,000,000 Mayo Clinic 4.000% Taxable Bonds, Series 2013 maturing on November 15, 2047.

Mayo Clinic also has guaranteed the payment of debt service when due on several other issues of revenue bonds, the proceeds of which were made available to direct or indirect controlled affiliates of Mayo Clinic. These other revenue bonds include:

- The Industrial Development Authority of the County of Maricopa Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2006 (the "2006 Arizona Bonds") currently outstanding in the principal amount of $50,000,000[*]

- The Jacksonville Economic Development Commission Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2006 (the "2006 Jacksonville Bonds") currently outstanding in the principal amount of $125,000,000[†]

- Wisconsin Health and Educational Facilities Authority Health Care Facilities Revenue Bonds (Luther Hospital) Series 2008 (the "2008 Wisconsin Bonds") currently outstanding in the principal amount of $74,300,000

- The Industrial Development Authority of the City of Phoenix, Arizona Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2014A and the Industrial Development Authority of the City of Phoenix, Arizona Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2014B (collectively, the "2014 Arizona Bonds") currently outstanding in the aggregate principal amount of $180,000,000.

Mayo Clinic has never been required to make a payment under any of its guarantees of the payment of debt service on the bonds described above. See "SECURITY FOR THE BONDS" and the notes to the audited Consolidated Financial Report of Mayo Clinic in Appendix B.

A total of $990,000,000 in principal amount of the bond issues listed above (including issues of bonds guaranteed by Mayo Clinic) currently bears interest at variable rates. Mayo Clinic has entered into separate standby purchase and credit agreements with different commercial banks to provide separate

[*] Mayo Clinic currently expects to redeem the 2006 Arizona Bonds on May 15, 2016 with funds available to Mayo Clinic. At this point, however, no assurances can be given that redemption of any of the 2006 Arizona Bonds will occur.

[†] Mayo Clinic currently expects to refund, for interest rate savings, the outstanding principal amount of the 2006 Jacksonville Bonds through one or more series of 2016 Tax-Exempt Bonds to be issued on or around May 3, 2016 in an amount sufficient, together with other moneys available to Mayo Clinic, to redeem or pay off all of the outstanding 2006 Jacksonville Bonds on May 15, 2016. At this point, however, no assurances can be given that the 2016 Tax-Exempt Bonds will be issued, or if so, when the refunding of any of the 2006 Jacksonville Bonds will occur.

liquidity in connection with any tenders for the purchase of several series of these variable rate bonds, the aggregate principal amount of which currently is $630,000,000. Mayo Clinic provides self-liquidity for the balance ($360,000,000 in principal amount) of these variable rate bonds.

Mayo Clinic's self-liquidity is currently enhanced by three separate lines of credit, consisting of a $100,000,000 line of credit from Wells Fargo Bank, National Association, a $100,000,000 line of credit from U.S. Bank National Association, and a $25,000,000 line of credit from The Northern Trust Company, each of which is specifically available for the purpose of providing liquidity in the event of a failed remarketing of its variable rate bonds. Mayo Clinic has an additional $200,000,000 line of credit with U.S. Bank National Association that may be used for general operating purposes.

Mayo Clinic has no interest rate swaps associated with any of its debt.

As discussed in "Management's Discussion – Strategic Capital Investments" in Appendix A, for 2016, Mayo Clinic expects its capital expenditures to total approximately $700 million; Mayo Clinic currently plans to spend an average of approximately $700 million annually from 2017 to 2019. Mayo Clinic anticipates that funding for these expenditures will be provided from a variety of sources and, if deemed appropriate, additional issues of bonds and other external borrowings.

## DEBT SERVICE REQUIREMENTS

The following table sets forth the scheduled principal and interest requirements for (i) the Bonds, (ii) the Minnesota Bonds, the Term Loans (collectively, the "Other Indebtedness") and (iii) the bond issues for which Mayo Clinic has guaranteed the payment of debt service (see "OUTSTANDING INDEBTEDNESS") for each annual period ending December 31.

| Year Ending December 31 | Bonds | | Other Indebtedness[1] | Mayo Guaranteed Debt[2] | Total Debt Service |
|---|---|---|---|---|---|
| | Principal | Interest | | | |
| 2016[3] | | | $129,552,656 | $20,834,875 | $ |
| 2017 | | | 83,971,332 | 20,842,938 | |
| 2018 | | | 83,979,337 | 20,816,850 | |
| 2019 | | | 83,392,513 | 20,816,125 | |
| 2020 | | | 84,167,994 | 20,802,325 | |
| 2021 | | | 83,900,376 | 20,757,750 | |
| 2022 | | | 127,574,506 | 20,735,000 | |
| 2023 | | | 143,643,274 | 20,688,975 | |
| 2024 | | | 125,552,325 | 20,653,563 | |
| 2025 | | | 112,218,287 | 20,616,600 | |
| 2026 | | | 112,612,993 | 20,545,988 | |
| 2027 | | | 112,983,574 | 20,476,863 | |
| 2028 | | | 152,285,163 | 20,403,363 | |
| 2029 | | | 153,120,713 | 20,329,913 | |
| 2030 | | | 154,114,067 | 20,250,650 | |
| 2031 | | | 120,282,147 | 40,420,000 | |
| 2032 | | | 149,347,500 | 11,891,500 | |
| 2033 | | | 115,755,594 | 46,191,500 | |
| 2034 | | | 116,031,920 | 46,196,500 | |
| 2035 | | | 116,310,021 | 46,185,500 | |
| 2036 | | | 116,573,802 | 46,185,000 | |
| 2037 | | | 178,478,151 | 4,500,000 | |
| 2038 | | | 194,442,055 | 4,500,000 | |
| 2039 | | | 153,561,000 | 4,500,000 | |
| 2040 | | | 151,860,688 | 4,500,000 | |
| 2041 | | | 155,166,363 | 4,500,000 | |
| 2042 | | | 154,164,900 | 4,500,000 | |
| 2043 | | | 149,120,400 | 4,500,000 | |
| 2044 | | | 121,575,900 | 4,500,000 | |
| 2045 | | | 121,750,600 | 4,500,000 | |
| 2046 | | | 121,745,300 | 4,500,000 | |
| 2047 | | | 121,560,000 | 4,500,000 | |
| 2048 | | | 25,824,611 | 38,701,956 | |
| 2049 | | | 25,802,750 | 38,705,000 | |
| 2050 | | | 25,817,083 | 38,706,522 | |
| 2051 | | | 25,766,472 | 38,706,022 | |
| 2052 | | | 25,802,000 | 38,703,000 | |
| Total | $ | | $4,229,808,365 | $789,664,275 | $ |

1. Interest payable on the 2000 Minnesota Bonds, 2002 Minnesota Bonds and 2008ABC Minnesota Bonds and the 2014 Minnesota Bonds; interest payable on the 2011A and 2011B Minnesota Bonds (from November 15, 2018); and interest payable on the 2011C Minnesota Bonds (from November 15, 2021) is based on a variable rate. An assumed rate of 2.5% was used to calculate interest payable on such bonds.
2. Includes 100% of scheduled debt service on the 2008 Wisconsin Bonds, the 2006 Arizona Bonds, the 2006 Jacksonville Bonds and the 2014 Arizona Bonds.
3. 2016 includes full calendar year interest for all existing indebtedness.

## USE OF PROCEEDS

The proceeds of the Bonds will be used by Mayo Clinic for eligible corporate purposes, including paying costs of issuing of the Bonds.

## ESTIMATED SOURCES AND USES OF FUNDS

The proceeds from the sale of the Bonds are expected to be applied as set forth below.

**Estimated Sources of Funds**

| | |
|---|---|
| Principal Amount of the Bonds | $300,000,000.00* |
| Total | $300,000,000.00* |

**Estimated Uses of Funds**

| | |
|---|---|
| Net to Mayo Clinic | $ |
| Costs of Issuance[1] | |
| Total | $300,000,000.00* |

[1] Includes Underwriters' discount and estimated fees and expenses of bond counsel, financial advisor, the Trustee, printers, rating services, certain expenses of Mayo Clinic, and a rounding amount.

## PLAN OF FINANCE; 2016 TAX-EXEMPT BONDS

Mayo Clinic currently expects that, at its request, the City of Rochester, Minnesota and the City of Jacksonville, Florida will issue one or more series of tax-exempt revenue bonds (the "2016 Tax-Exempt Bonds") and make the proceeds of the 2016 Tax-Exempt Bonds available to Mayo Clinic or to Mayo Clinic Jacksonville. The 2016 Tax-Exempt Bonds are expected to be issued on or around May 3, 2016 and will bear interest at variable rates. The proceeds of the 2016 Tax-Exempt Bonds will be used together with other available moneys to redeem or pay off all of the outstanding 2006 Minnesota Bonds and all of the 2006 Jacksonville Bonds on May 15, 2016, expected to result in interest rate savings, and for certain capital projects. Mayo Clinic also currently expects to redeem the 2006 Arizona Bonds on May 15, 2016 with its own funds.

Mayo Clinic will be obligated to make payments due on the 2016 Tax-Exempt Bonds through a loan agreement with the City of Rochester, Minnesota and through a guarantee of Mayo Clinic Jacksonville's obligations to make payments due on the City of Jacksonville, Florida 2016 Tax-Exempt Bonds.

If issued, the aggregate amount of 2016 Tax-Exempt Bonds issued on behalf of Mayo Clinic and/or Mayo Clinic Jacksonville may change based (among other things) on the amount of Bonds issued in connection with this Offering Memorandum; however, the aggregate principal amount of 2016 Tax-Exempt Bonds is not expected to exceed $250,000,000, and the total increase in outstanding indebtedness of Mayo Clinic after the issuance of the Bonds and 2016 Tax-Exempt Bonds is not expected to exceed $300,000,000.

* Preliminary, subject to change.

At this point, no assurances can be given that the 2006 Arizona Bonds will be redeemed, or that any or all of the 2016 Tax-Exempt Bonds will be issued, or if so, when the refunding of any of the 2006 Minnesota Bonds or any of the 2006 Jacksonville Bonds will occur.

## SECURITY FOR THE BONDS

The Bonds are general, unsecured obligations of Mayo Clinic issued pursuant to the Indenture. The covenants and agreements of Mayo Clinic in the Indenture are for the equal and ratable benefit and security of the Holders of all Bonds.

### Negative Pledge

Mayo Clinic's obligations under the Indenture are not secured by a lien on the assets, property or revenues of Mayo Clinic or any of its affiliates. However, in the Indenture, Mayo Clinic agrees that it will not permit any Liens other than Permitted Encumbrances to be placed on any of its property or on any of the property of its affiliates, unless such Lien is also granted to secure the Bonds. Pursuant to the terms of the loan agreements of Mayo Clinic relating to the Minnesota Bonds, the Term Loans and the Bonds and the terms of the guarantees of Mayo Clinic relating to the 2006 Jacksonville Bonds, the 2006 Arizona Bonds, the 2008 Wisconsin Bonds and the 2014 Arizona Bonds, any Lien (other than a Permitted Encumbrance) so granted must also be granted to secure such bonds. The term "Lien" means any mortgage or pledge of, security interest or lien, charge of other encumbrance on any Property which secures any obligation or otherwise grants a right to a person other than Mayo Clinic or any of its affiliates, and the term "Property" means any and all right, title and interest in and to any or all property, whether real or personal, tangible or intangible and wherever situated, including cash. See Appendix C "SUMMARY OF CERTAIN PROVISIONS OF THE INDENTURE" for a description of the items that are Permitted Encumbrances.

### Other Debt

Mayo Clinic is liable for the payment of the other indebtedness. Mayo Clinic is also directly liable on or has guaranteed other debt. See "OUTSTANDING INDEBTEDNESS" and Note 8 in Appendix B.

### Mayo Clinic Affiliates Not Directly Liable

The consolidated audited financial statements of Mayo Clinic for the years ended December 31, 2015 and 2014 are set forth in Appendix B. Such financial statements include the assets and operations of entities such as Mayo Clinic-Saint Marys Hospital, Mayo Clinic-Methodist Hospital, Mayo Clinic Jacksonville, Mayo Clinic Arizona and Mayo Clinic Health System which are required to be consolidated with the financial statements of Mayo Clinic under generally accepted accounting principles. While Mayo Clinic is the direct or indirect corporate parent of such consolidated entities, such affiliates are not directly liable on any of the Minnesota Bonds, the Bonds or the Term Loans. Consequently there would be no direct recourse against the assets or income of any consolidated entity other than Mayo Clinic in the event a payment is required under the Indenture. Some of the assets of the consolidated entities may be or become subject to legal or contractual restrictions and may not be available to Mayo Clinic to satisfy its obligations.

Mayo Clinic is the only obligor to the Indenture and consequently is the only entity whose financial results are included in Mayo Clinic's Consolidated Financial Report that is obligated to make payments on the Bonds. However, in the Indenture, Mayo Clinic agrees to exercise all control or rights it may have with respect to its direct or indirect subsidiaries to cause them to pay, loan or otherwise transfer

to Mayo Clinic, such amounts (if any) as are necessary to duly and punctually pay the principal and purchase price of, premium, if any, and interest on the Bonds when and as the same becomes due and payable, whether at maturity, upon redemption, by acceleration or otherwise.

Although Mayo Clinic currently reserves the right to approve any significant debt issuance, asset transfers or corporate reorganizations of its controlled affiliates and subsidiaries, there are no provisions in the Indenture or any other agreement executed in connection with the Bonds that require Mayo Clinic to limit the foregoing activities of its direct or indirect subsidiaries.

## INVESTMENT CONSIDERATIONS

### Factors That Could Affect the Future Financial Condition of Mayo Clinic and Affiliates

Mayo Clinic and several of its affiliates are health care providers that derive significant portions of their revenues from Medicare, Medicaid, HMOs and other third-party payor programs. Mayo Clinic is subject to governmental regulation applicable to health care providers and its receipt of future revenues is subject to, among other factors, federal and state policies affecting the health care industry and other conditions that are impossible to predict. Such conditions may include limits on increasing charges and fees charged by Mayo Clinic, changes in federal and state laws and regulations affecting payments for health services, the continued increase in managed care or development of new third-party payment policies which reduce revenues, unanticipated competition from other health care providers, and changes in demand for health services.

Mayo Clinic's revenues and expenses may be adversely affected by the current economic climate and future economic conditions. The receipt of future revenues by Mayo Clinic is also subject to factors such as the demand for Mayo Clinic services, its ability to provide the services required by patients, Mayo Clinic management capabilities, its ability to control expenses, its relationships with HMOs and other third-party payor programs, competition, rates, costs, third-party reimbursement, legislation and governmental regulation, receipt of private contributions, economic developments in the service areas, general economic conditions and other conditions which are impossible to predict.

No assurances can be given that patient utilization or revenues available to Mayo Clinic from its operations will remain stable or increase. Mayo Clinic expects that it will experience increases in operating costs due to inflation and other factors. However, there is no assurance that cost increases will be matched by increased patient revenue in amounts sufficient to generate an excess of revenues over expenses or that Mayo Clinic will be able to control expenses in periods of inflation.

The risk factors discussed below should be considered in evaluating the ability of Mayo Clinic to make payments in amounts sufficient to meet its obligations under the Indenture. This discussion is not exhaustive.

### Health Care Industry Factors Affecting Mayo Clinic and Affiliates

The health care industry is highly dependent on a number of factors that may limit the ability of Mayo Clinic to meet its obligations under the Indenture, many of which are beyond its control. Among other things, participants in the health care industry are subject to, and may be adversely affected by, significant regulatory requirements of federal, state and local governmental agencies and independent professional organizations and accrediting bodies, technological advances and changes in treatment modes, new pharmaceutical and genetic developments and products, various competitive factors and changes in third-party reimbursement programs. Discussed below are certain of these factors which could have a significant impact on the future operations and financial condition of Mayo Clinic and its affiliates.

Mayo Clinic's ability to pay its obligations under the Indenture could be adversely affected by legislation, regulatory actions, economic conditions, increased competition from other health care providers, changes in the demand for health care services, government and third-party payor reimbursement changes, demographic changes, and malpractice claims and other litigation. The Underwriters have not made any independent investigation of the extent to which any such factors may have an adverse impact on the financial condition of Mayo Clinic and its affiliates.

**Patient Protection and Affordable Care Act and Healthcare Reform Initiatives**

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the laws are referred to as the "ACA"). The ACA is intended to address disparities in access, cost, quality and the delivery of healthcare to United States residents.

The changes to various aspects of the healthcare system in the ACA are far-reaching and include substantial adjustments to Medicare reimbursement, establishment of individual and employer mandates for health insurance coverage, extension of Medicaid coverage to certain populations, provision of incentives for employer-provided healthcare insurance, restrictions on physician-owned hospitals, and increased efficiency and oversight provisions. Some of the provisions of the ACA took effect immediately, while others are phased in over time, ranging from one year to ten years. Most of the significant healthcare coverage reforms began in 2014. The ACA also requires the promulgation of substantial regulations with significant effects on the healthcare industry.

The ACA reforms the sources and methods by which consumers will pay for healthcare for themselves and their families. The ACA also places new requirements on employers related to the provision of health insurance to their employees and dependents. These reforms are expected to expand the base of consumers of healthcare services. One of the primary goals of the ACA is to provide or make available, or subsidize the premium costs of, healthcare insurance for consumers who are currently uninsured (or underinsured) and who fall below certain income levels. The ACA proposes to accomplish that objective through various provisions, including:

- creating state organized insurance markets (referred to as exchanges) in which individuals and small employers can purchase healthcare insurance for themselves and their families or their employees and dependents;

- providing subsidies for health insurance premium costs to individuals and families based upon their income relative to the federal poverty level (the "FPL");

- mandating that individual consumers obtain and certain employers provide a minimum level of healthcare insurance, and providing for penalties or taxes on consumers and employers that do not comply with these mandates;

- establishing insurance reforms that expand coverage generally through such provisions as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps; and

- expanding existing public programs, including Medicaid for individuals and families.

To the extent all or any of those provisions produce the intended result, an increase in utilization of healthcare services by those who are currently avoiding or rationing their healthcare can be expected and bad debt expenses may be reduced. Management of Mayo Clinic cannot predict what impact the

increased enrollment in public programs and exchange plans will have on reimbursement rates from the federal and state governments and commercial carriers, or on the net revenues for the organization.

Some of the specific provisions of the ACA that may affect hospital operations, financial performance or financial conditions are described below. This listing is not comprehensive. The ACA is complex and comprehensive, and includes myriad new programs and initiatives and changes to existing programs, policies, practices and laws.

- With varying effective dates, the annual Medicare market basket updates for many providers, including inpatient and outpatient hospital services, will be adjusted based on a ten year average of national productivity and will be reduced by specified percentages each year.

- Commencing in federal fiscal year 2014, Medicare disproportionate share hospital ("DSH") payments (i.e., payments a provider receives from the federal government to help defray the cost of treating the uninsured) were reduced by 75%. DSH payments are determined by a formula that takes into account the national number of consumers who do not have healthcare insurance and the amount of uncompensated care provided by a hospital. However, due in part to reports of discrepancies between the proportion of uncompensated care provided at hospitals and the proportion of DSH payments being distributed to those hospitals, a provision in the ACA reduced total DSH payments by 75%, which 75% was then redistributed based on a formula more specifically aimed at calculating uncompensated care at hospitals, with uncompensated care being predicted to decline due to other provisions of the ACA. The result of the change is predicted to be a reduction in total Medicare DSH payments by approximately $22 billion for fiscal years 2014-2019. The ACA also mandated cuts to Medicaid DSH payments. The cuts, which have been delayed several times, are currently scheduled to reduce total Medicaid DSH payments by $35 billion for fiscal years 2018-2025.

- Through September 30, 2019, payments under the "Medicare Advantage" programs (Medicare managed care) are or will continue to be reduced, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans and may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs.

- States have the option to expand their Medicaid programs to a broader population, with incomes up to 133% of the FPL.

- Medicare reduces payments to hospitals found to have an excess re-admissions ratio for certain conditions and this information will be made available to the public.

- Commencing in federal fiscal year 2015, Medicare payments to certain hospitals that fall into the top 25% of national risk-adjusted hospital acquired conditions rates are reduced by 1%. Federal payments to states for Medicaid services related to hospital acquired conditions are prohibited.

- Certain Medicare providers, including hospitals, are able to participate in a Medicare shared savings program that promotes accountability for the care of Medicare beneficiaries and encourages coordination of care and other efficiencies through entities called Accountable Care Organizations ("ACOs"). As of this date, Mayo Clinic has not elected to form an ACO.

- A value-based purchasing program is established under the Medicare program. This program provides incentive payments to hospitals based on their performance on certain quality and efficiency measures. In order to fund the incentive payments awarded to hospitals under this program, the Centers for Medicare and Medicaid ("CMS") phased in reductions to Medicare inpatient payments.

- To reduce waste, fraud, and abuse in public programs, the ACA provides for provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs. It also requires Medicare and Medicaid program providers and suppliers to establish compliance programs. The ACA requires the development of a database to capture and share healthcare provider data across federal healthcare programs and provides for increased penalties for fraud and abuse violations, and increased funding for anti-fraud activities.

- The ACA establishes an Independent Payment Advisory Board to develop proposals to improve the quality of care and to recommend proposals to limit Medicare spending growth. Beginning January 15, 2014, if CMS determines that the Medicare spending growth rate exceeds a statutorily prescribed target, then the Independent Payment Advisory Board is required to develop proposals to reduce the growth rate and the Secretary of HHS must implement those proposals, unless Congress enacts legislation related to the proposals.

- The ACA imposes substantial new data reporting obligations on hospital initiatives to improve the quality of care, reduce errors and improve health outcomes.

- The ACA immediately imposed additional requirements upon nonprofit hospitals to maintain their tax-exempt status, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and control the billing and collection processes. Additionally, tax-exempt hospitals must conduct a community needs assessment at least once every three taxable years and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

Broadly speaking, the provisions of the ACA that encourage or mandate healthcare coverage for individuals can be expected to increase demand for health care and reduce the amount of uncompensated care that Mayo Clinic and its affiliates provide. However, revisions to the Medicare reimbursement program could reduce revenues. Therefore, the impact of the PACA on the operations of Mayo Clinic and its affiliates cannot be currently ascertained, and it may have a material impact, either positive or negative, on their operations.

On June 28, 2012, the Supreme Court of the United States upheld the constitutionality of the ACA individual mandate for individuals to buy health insurance as a constitutional exercise of Congress's power to levy taxes. However, the Court found that the provision of the ACA that requires states to expand Medicaid to all people with income below 133% of the poverty level or lose the states' existing Medicaid funds, was an improper exercise of Congress' spending powers under the Constitution and amounted to coercion. The Court held that this requirement was severable from the rest of the law; therefore the additional Medicaid funds may still be made available to states which agree to the expansion of their Medicaid programs, but Congress cannot withhold all Medicaid funds from those states that opt

out of the expansion. As a result, some states have elected not to expand their Medicaid program, which may affect the number of uninsured people to whom Mayo Clinic provides care.

On June 25, 2015, the Supreme Court of the United States issued its opinion in *King v. Burwell* holding that the tax credit subsidies provided in the ACA apply equally to state-run exchanges and the federal exchange, removing potential disparate treatment of program participants nationally.

The ultimate outcomes of legislative attempts to repeal or amend the ACA and other legal challenges to the ACA are unknown and their impact on the Mayo Clinic's operations cannot be determined. Mayo Clinic is analyzing the ACA and will continue to do so in order to assess its effects on current and projected operations, financial performance and financial condition. However, management of Mayo Clinic cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation.

**Overview of Medicare and Medicaid Programs**

Medicare and Medicaid are the commonly used names for health care reimbursement or payment programs governed by certain provisions of the federal Social Security Act Amendments of 1965. The federal government, as the country's largest payer of health care services, uses reimbursement as a key tool to implement health care policies, to allocate health care resources and to control utilization, facility and provider development and expansion, and technology use and development. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs. Health care reform legislation continues these practices. These laws reflect the national policy that persons who are elderly and persons who are poor should have access to medical care regardless of ability to pay. Mayo Clinic serves this population and it is unlikely that Mayo Clinic and its affiliates could attract sufficient numbers of private pay patients to their facilities to become self-sufficient without reimbursement from governmental sources.

Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, disabled, or qualify for Medicare's End Stage Renal Disease Program. Medicare Part A covers inpatient hospital, home health, nursing home care and certain other services, and Medicare Part B covers certain physician services, certain outpatient ancillary care services, medical supplies and durable medical equipment. Medicare Part C, the Medicare Advantage program, enables Medicare beneficiaries to choose to obtain their benefits through a variety of private, managed care, risk-based plans.

Medicare Part D makes outpatient prescription drug benefits available to Medicare beneficiaries. The private Medicare Part D plans are funded through premium payments from enrolled Medicare beneficiaries and subsidies from the federal government. Enrollment is available on an ongoing and intermittent basis. While participation in the program is voluntary, those who wait to enroll beyond their initial point of eligibility are penalized with additional surcharges which increase over time. The ACA includes changes to the Medicare Part D program, including the gradual reduction of the cost sharing burden by beneficiaries under Medicare Part D (the so-called "donut hole"). Although Medicare Part D reimbursement does not cover inpatient prescriptions, changes in enrollment or program administration could affect Mayo Clinic's revenue. Going forward, an expansion of coverage for outpatient pharmaceutical therapy may reduce Mayo Clinic's admissions or shift the characteristics of those patients that are admitted.

Medicaid is designed to pay providers for care given to the indigent and other persons who qualify based on certain conditions. Medicaid is funded by federal and state appropriations and is

administered by an agency of the applicable state. Under the ACA, states have the option to expand Medicaid eligibility to cover individuals with income under 133% of the FPL.

**Conditions of Participation**. Hospitals must comply with standards called "Conditions of Participation" in order to be eligible for Medicare and Medicaid reimbursement. Centers for Medicare and Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS") is the federal agency responsible for ensuring that hospitals meet the regulatory Conditions of Participation. Generally, under Medicare rules, hospitals accredited by the Joint Commission (a private nonprofit corporation that accredits health care programs and providers in the United States) and other CMS approved accreditation bodies are deemed to meet the Conditions of Participation. Mayo Clinic's facilities are currently accredited by the Joint Commission but there is no guarantee that Mayo Clinic will continue to be accredited or will meet the Conditions of Participation in the future. Failure to maintain accreditation or to otherwise comply with the Conditions of Participation could have a materially adverse effect on the continued participation in the Medicare and Medicaid programs, and ultimately on the revenues of Mayo Clinic.

**Medicare Reimbursement**

**Overview**. Medicare is administered by CMS, which delegates to the states the survey process for certifying those health care organizations to which CMS will make payment. The HHS's rule-making authority is substantial and the rules are extensive and complex. Substantial deference is given by courts to rules promulgated by HHS.

Most Medicare hospital services are paid at a fixed rate per case under the reimbursement methods described below. Some Medicare recipients, however, enroll in Medicare Advantage managed care plans, which reimburse providers on a contractually determined basis. Health care providers that participate in the Medicare program must agree to be bound by the terms and conditions of the program such as meeting the quality standards for rendering covered services and adopting and enforcing policies to protect patients from certain discriminatory practices.

The ACA introduces changes to the Medicare program that have been estimated by the Congressional Budget Office to reduce the cost of the program over the next ten years by approximately $455 billion. The ACA reduces cost sharing by Medicare beneficiaries for certain preventive services and wellness visits and expands coverage for these services. In addition, the ACA includes programs that link Medicare payments for hospitals and physicians with quality outcomes and the development of new patient care models that stress primary care and community-based care. The objective of these programs is to manage chronic diseases better and to reduce inpatient admissions and other high cost care provided by health care facilities, such as hospitals and nursing homes. While additional governmental reporting, oversight and audits are a certainty, it is difficult to determine what effect the health care reform legislation and its implementation will ultimately have on the financial or operating condition of Mayo Clinic or its competitors in the future.

The Budget Control Act of 2011 (the "Budget Control Act") limits the federal government's discretionary spending caps at levels necessary to reduce expenditures by $917 billion from the current federal budget baseline between federal fiscal years 2012 and 2021. Social Security, Medicaid and other entitlement programs are not affected by the limit on discretionary spending caps. The Budget Control Act also created a new Joint Select Committee on Deficit Reduction (the "Supercommittee") tasked with making recommendations to further reduce the federal deficit by $1.2 trillion. Due to the Supercommittee's failure to act within the time specified in the Budget Control Act, the debt ceiling was to be automatically raised and sequestration (the process of automatic across the board cuts) was to be triggered in an amount necessary to achieve $1.2 trillion in savings. A wide range of spending is

exempted from sequestration including: Social Security, Medicaid, Veteran's benefits and pensions, specified federal retirement funds, child nutrition and other programs. Medicare is not exempted from sequestration but Medicare payment reductions are limited to 2% of total program costs.

The American Taxpayer Relief Act of 2012 ("ATRA") postponed this scheduled reduction until March 1, 2013. The Office of Management and Budget issued a report to Congress detailing the effects of this reduction to be a 2% Medicare spending reduction and CMS confirmed that the 2.0% reduction to Medicare providers and insurers was for services provided on or after April 1, 2013. ATRA significantly affects hospital Medicare reimbursement in that it requires the Medicare program to recoup funds from hospitals based on changes in documentation and coding that have increased Medicare inpatient prospective payment system payments but that do not represent real increases in the intensity of services provided to patients. In the final inpatient prospective payment system regulations for federal fiscal year 2014, CMS stated that it intends to phase in this recoupment over time, starting with a 0.8% reduction in the Medicare standardized amount for fiscal years 2014 and 2015. Additional recoupment adjustments are planned for federal fiscal years 2016 and 2017.

In addition on December 26, 2013, President Obama signed into law a bipartisan and bicameral budget agreement known as the Bipartisan Budget Act of 2013 ("Bipartisan Budget Act") which staved off further sequestration cuts while keeping the current Medicare sequestration cuts in place. Therefore, the 2% reduction to Medicare providers and insurers has continued into 2015. Certain commercial Medicare Advantage plans are passing this reduction on to health care providers. The Bipartisan Budget Act also included Medicare cuts such as a restructuring of Medicaid disproportionate share payments reductions by delaying the fiscal year 2014 disproportionate share payment cuts until fiscal year 2016, but increasing the overall level of reductions and extending cuts through fiscal year 2023.

It is possible that Congress will take action to eliminate some or all of the reductions in the future and any Congressional action could be made retroactive in order to eliminate some or all of the cuts even to the extent they were imposed. However, there is no certainty that Congress will take any action. Absent further Congressional action these automatic spending cuts will become permanent. Because Congress may make changes to the budget in the future, it is impossible to predict the impact any spending cuts may have upon Mayo Clinic. Similarly, it is impossible to predict whether any automatic reductions to Medicare may be triggered in lieu of other spending cuts that may be proposed by Congress. If and to the extent Medicare and/or Medicaid spending is reduced under either scenario, this may have a material adverse effect upon the financial condition of Mayo Clinic, including a disproportionate impact on hospital providers.

**Inpatient Services**. Medicare payments for operating expenses incurred in the delivery of inpatient hospital services are based on a prospective payment system ("PPS"), which pays hospitals a fixed amount for each Medicare inpatient discharge based upon patient diagnosis and certain other factors used to classify each patient into a Diagnosis Related Group ("DRG") or, more recently, the Medical Severity Diagnosis Related Group ("MS-DRG"). MS-DRG rates are adjusted annually by the use of an "update factor" based on the projected increase in a market basket inflation index which measures changes in the costs of goods and services purchased by hospitals, but the adjustments historically have not kept pace with inflation. Inpatient psychiatric services are also reimbursed on a case-mix adjusted prospective payment methodology.

With limited exceptions, such payments are not adjusted for actual costs, variations in intensity of illness, or length of stay. If a hospital treats a patient and incurs less cost than the applicable MS-DRG-based payment, the hospital is entitled to retain the difference. Conversely, if a hospital's cost for treating the patient exceeds the MS-DRG-based payment, the hospital generally will not be entitled to any additional payment. If a case is unusually complex or expensive, it may qualify for an "outlier" payment,

which is added to the MS-DRG-adjusted base rate payment. There can be no assurance that payments under the PPS will be sufficient to cover all actual costs of providing inpatient hospital services to Medicare patients.

Medicare and Medicaid currently make additional payments to hospitals that serve a disproportionate share of low income patients. The ACA incrementally decreases the Medicare DSH payments by $22 billion from 2014 through 2019 and Medicaid DSH payments by $35 billion from 2018 through 2025, based on an assumption that the law's new coverage and access provisions will substantially reduce uncompensated care provided by hospitals. However, the Supreme Court decision striking down mandatory expansion of Medicaid has caused some to question whether states choosing not to expand Medicaid programs will prevent reductions in uncompensated care from offsetting DSH payment reductions as much as originally anticipated, which could result in financial strain in providers such as Mayo Clinic.

Medicare also makes additional payments to hospitals engaged in graduate medical education residency training programs. The ACA includes some changes to funding for primary care residency programs and provides grants to establish teaching health centers, which are community-based ambulatory patient care centers. The ACA also establishes other programs to encourage the training and development of more primary care residents (including family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry and geriatrics) and the primary care workforce.

The ACA continues and expands earlier Congressional measures taken to address the growing cost of the Medicare and Medicaid programs and expands programs to improve the quality of care with reductions in reimbursements for excessive readmissions, medical errors and preventable conditions such as hospital acquired infections. CMS periodically promulgates regulations, such as its annual inpatient PPS rules, to adjust the rates paid to hospitals based on its continuing experience with hospital operating and capital costs, and to implement various quality improvement, patient safety and fraud and abuse programs. For example, the annual inpatient PPS rules for federal fiscal years 2008 and 2009 included, and then expanded, a list of preventable conditions or consequences (so-called "never events") for which Medicare would not pay any additional costs of treatment. CMS also reduces payments to hospitals that do not successfully report quality measures adopted under the program by two percent from the percentage increase that would otherwise apply to their payment rates.

The 2014 PPS rule included a payment rate update for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful users of electronic health records of 1.4% and for long-term care hospitals of 1.1% for fiscal year 2015. Under the Hospital Value-Based Purchasing Program, the 2014 rule also increased the applicable percent reduction to 1.5% of the base operating DRG payment amounts to all participating hospitals. Additionally, in fiscal year 2015, the maximum reduction in payments under the Hospital Readmissions Reduction program increased from 2 to 3 percent, and Medicare payments to hospitals ranking in the lowest 25% for hospital-acquired conditions were reduced by 1% beginning in 2015. There can be no assurance that future changes in classifications of patient hospitalizations or revisions to annual documentation and coding adjustments or other payment update measures implemented in future prospective payment regulations will not result in fluctuations or declines in revenue. Depending on the mix of future services delivered, the overall result of these changes to the inpatient PPS reimbursement rules may be to reduce Medicare reimbursement to Mayo Clinic and its affiliates.

**Outpatient Services**. Medicare payments for hospital outpatient services also are established through a PPS methodology. Under outpatient PPS, procedures, evaluations, management services, drugs and devices in outpatient departments are classified into one of approximately 750 groups called Ambulatory Payment Classifications ("APCs"). Services provided within an APC are similar clinically

and in terms of the resources they require. Each APC has been assigned a weight derived from the median hospital cost of the services in the group relative to the median hospital cost of the services included in the APC for mid-level clinic visits, adjusted to account for variations in hospital labor costs across geographic regions. Payment rates for each APC are then calculated by multiplying the relative weight for an APC by a conversion factor to arrive at a dollar figure.

Outpatient PPS includes additional adjustments for transitional pass-through payments and outlier payments. Transitional pass-through payments are costs associated with new technology items (drugs, biologicals and medical devices) that were not reflected in the data that CMS used to calculate outpatient PPS payment rates, and are intended to allow for adequate payment of new and innovative technology until there is enough data to incorporate the costs for these items into the base APC group.

APCs include payment for related ancillary services provided in conjunction with a procedure or medical visit. Although hospitals may receive payment for more than one APC for an encounter, payment for multiple surgical APC procedures are subject to substantial discounting.

Outpatient renal dialysis services are reimbursed on the basis of prospective reimbursement, although different rates are paid for hospital-based and free-standing facilities, and are adjusted for geographic differences in labor costs. This composite rate is the same regardless of whether the treatment is furnished in the facility or in the patient's home to incentivize home dialysis, and must be accepted by the facility as payment in full for covered outpatient dialysis.

Under outpatient PPS, a hospital with costs exceeding the applicable payment rate would incur losses on such services provided to Medicare beneficiaries. There can be no assurance that outpatient PPS payments will be sufficient to cover all of Mayo Clinic's actual costs of providing hospital outpatient services to Medicare patients.

On November 13, 2015 CMS issued its annual rule updating payment policies and rates for both outpatient hospital departments and ambulatory surgery centers beginning January 1, 2016. It is unclear what impact the new rates and quality reporting requirements will have on Mayo Clinic's outpatient revenue.

**Physician Payments**. Payment for physician services is provided by Part B of Medicare. Under Part B, physician services are reimbursed in an amount equal to the lesser of actual charges or the amount determined under a fee schedule known as the "resource-based relative value scale" or "RBRVS." RBRVS sets a relative value for each physician service; that value is then multiplied by a geographic adjustment factor and a nationally-uniform conversion factor to determine the amount Medicare will pay for each service.

The relative values for physician services contained in the RBRVS are based on a work component intended to reflect the time and intensity of effort required to provide the service; a practice expense component which includes costs such as office rents, allied health support salaries, equipment and supplies; and a component for the cost of malpractice insurance.

CMS uses a resource-based system of calculating practice expense relative value units ("RVUs") based on actual practice expense data to replace the historical charge-based practice expense RVU system that was previously used. The methodology for computing practice expense RVUs provides for higher practice expense RVUs for services performed in a doctor's office, the patient's home, or a facility or institution other than a hospital, skilled nursing facility ("SNF") or ambulatory surgical center ("ASC"). CMS also uses a resource-based system of calculating malpractice expense RVUs. The formulae used to calculate physician payments under the RBRVS methodology do not necessarily reflect the actual costs of

such services. There can be no assurance that payments to Mayo Clinic and its affiliates under the Medicare program will be adequate to cover their costs of providing physician services.

Mayo Clinic has a mix of entities that participate and do not participate under Medicare Part B. Providers such as Mayo Clinic, Mayo Clinic Arizona and Mayo Clinic Jacksonville that are not reimbursed directly by Medicare for physician services ("Non-Participating Physicians") may charge Medicare patients a fee for a covered service which is greater than the amount Medicare reimburses for that service, subject to several limitations. First, the patient pays the full amount of the bill, subject to the Medicare limiting charge requirement (see below) and is reimbursed by Medicare, but only at the fee scheduled amount established by Medicare for that service. As a result, the patient is responsible for paying the difference between the full amount billed by the physician for the service and the amount of Medicare reimbursement the patient receives. The collection of the difference is referred to as "balance billing." Second, as described in greater detail below, the fees that Non-Participating Physicians may charge Medicare patients are subject to certain limitations.

Medicare limits the total amount Non-Participating Physicians may charge Medicare patients through the establishment of a limiting charge, which restricts the total amount a Non-Participating Physician may bill and recover from a Medicare patient for a procedure to 115% of the applicable Medicare reimbursement levels (the applicable Medicare reimbursement level for Non-Participating Physicians generally is 95% of the RBRVS fee schedule amount). Thus, the limiting charge is generally set at a level equal to approximately 109% of the RBRVS fee schedule amount.

Medicare requires CMS to adjust the Medicare Physician Fee Schedule ("MPFS") payment rates annually; the MPFS covers payments for more than 7,000 types of services in physician offices, hospitals, and other settings based on a formula. In each of the past several years, the annual adjustment formula (known as the sustainable growth rate) has yielded a reduction in physician payments but Congress has taken legislative action each year to prevent such reductions from taking effect. The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") replaced the sustainable growth rate formula with statutorily prescribed physician payment updates and incentives. Under the provisions of MACRA, the sustainable growth rate formula is repealed and replaced with the following statutorily prescribed updates:

- Beginning July 1, 2015, and effective January 1 of each subsequent calendar year through 2019, Medicare physician payments will be increased 0.5%.

- Beginning January 1, 2020, and carrying through 2025, physician payments will not be updated.

- Beginning January 1, 2026, and effective January 1 of each subsequent calendar year, physician payments will be increased 0.75% for physicians who adequately participate in qualified alternative payment models, but only 0.25% for those who do not.

It is generally expected that MACRA will accelerate progress toward physician-hospital integration. MACRA also includes provisions affecting hospitals, post-acute care providers, ambulance services, payors and other health care industry stakeholders. It is not possible at this time to accurately predict the effect that these changes will have on the financial condition of Mayo Clinic.

**Capital Expenditures**. Medicare payments for capital-related costs associated with providing services to Medicare beneficiaries are based upon a PPS system similar to that applicable to operating costs. Payment for capital related costs for all hospitals are determined based on a standardized amount referred to as the federal rate.

Under PPS, payments for capital costs are calculated by multiplying the federal rate by the MS-DRG weight for each discharge and by a geographical adjustment factor. The payments are subject to further adjustment by a disproportionate share hospital factor that contemplates the increased capital costs associated with providing care to low income patients, and an indirect medical education factor that contemplates the increased capital costs associated with medical education programs. As noted above, the ACA includes reductions over time to the disproportionate share payments.

There can be no assurance that payments under the PPS inpatient capital regulations will be sufficient to fully reimburse Mayo Clinic for its capital expenditures.

**Medical Education Costs**. Under PPS, teaching hospitals receive additional payments from Medicare for certain direct and indirect costs related to their graduate medical education ("GME") programs. Direct GME payments compensate teaching hospitals for the cost directly related to educating residents. Such costs include the residents' stipends and benefits, the salaries and benefits of supervising faculty, other costs directly attributable to the GME program, and allocated overhead costs. Payment for direct medical education costs are calculated based upon set formulae taking into account hospital-specific medical education costs associated with each resident, the number of full-time equivalent residents, and the proportion of Medicare inpatient days to non-Medicare inpatient days. Indirect GME payments compensate teaching hospitals for the higher patient care costs they incur relative to non-teaching hospitals. Those indirect payments are issued as a percentage adjustment to the PPS payments. The calculation for both the direct part and the indirect part of Medicare payments for GME include certain limitations on the number and classification of full-time equivalent residents reimbursed by Medicare.

The formulae used to determine payments for medical education do not necessarily reflect the actual costs of such education, and the federal government will continue to evaluate its policy on graduate medical education and teaching hospital payments. There can be no assurance that payments to Mayo Clinic and its affiliates under the Medicare program will be adequate to cover their direct and indirect costs of providing medical education to interns, residents, fellows and allied health professionals. Additionally, these payments are vulnerable to reduction or elimination. The direct and indirect medical education reimbursement programs have repeatedly emerged as targets in the legislative efforts to reduce the federal budget deficit.

**Outlier Payments**. As noted above, hospitals are eligible to receive additional payments under the inpatient PPS for individual cases incurring extraordinarily high costs. Historically, the amount of an outlier payment was based, in part, on the hospital charges for a particular case as compared to that hospital's cost-to-charge ratio. As the hospital specific cost-to-charge ratio was calculated based on the most recently settled cost report, it was typically many months or years old and out of date.

Following an audit of aggressive pricing strategies at one of the nation's largest hospital chains, and a determination that some hospitals might be manipulating current hospital charge data to maximize reimbursement from Medicare under the outlier payment provisions, the Office of the Inspector General of HHS ("OIG") began investigating past outlier billing practices, and CMS amended the regulations on how outlier payments were to be calculated in the future. The methodology for calculating outlier payments is designed to prevent hospitals from manipulating the outlier formula to maximize reimbursement and allows for recovery of overpayments in certain cases.

The OIG continues to scrutinize outlier payments in an effort to determine whether outlier payments to the hospitals were paid in accordance with Medicare regulations or whether such payments were the result of potentially abusive billing practices. While Mayo Clinic believes that it has calculated its outlier payments appropriately, there can be no assurance that Mayo Clinic will not become the subject

of an investigation or audit with respect to its past outlier payments, or that such an audit would not have a material adverse impact on Mayo Clinic. Moreover, there can be no assurance that any future revisions to the formula for calculating outlier payments will not reduce the payments to Mayo Clinic and its affiliates, or that any such reduction will not have a material adverse impact on Mayo Clinic and its affiliates.

**Medicare Managed Care Program**. Every individual entitled to Medicare Part A benefits and who is enrolled in Medicare Part B (with the exception of individuals who suffer from End Stage Renal Disease) may elect coverage under either the traditional Medicare fee for service program (Parts A and B) or a Medicare managed care (Part C) program, known as the Medicare Advantage Program. The Medicare Advantage program is designed to expand the number and types of private regional plans available to beneficiaries as an alternative to traditional Parts A and B Medicare coverage. Payments for Medicare Advantage plans are based on competitive bids to the government rather than administered pricing.

Public and private health maintenance organizations, preferred provider organizations, fee for service and medical savings account plans may qualify as authorized Medicare Advantage plans. With limited exceptions, Medicare Advantage plans are risk-bearing programs that accept a fixed annual amount in return for providing beneficiaries with a defined level of benefits (basic or basic plus supplemental), either directly or through arrangements with other providers. All Medicare Advantage plans are required to provide coverage, even if out of network, for emergency services, renal dialysis services provided while the enrollee was temporarily outside of the plan's service area, post-stabilization care services (under limited circumstances) and services for which coverage was denied but, following appeal by the enrollee, were determined to be covered services. Providers wishing to participate in Medicare Advantage plans are subject to specific requirements concerning enrollee protection and accountability.

The shift of Medicare eligible beneficiaries from traditional Part A and Part B coverage to Part C Medicare Advantage programs was intended to increase competitive pressure to improve benefits, reduce premiums and generate cost reductions. However, because the cost to the Medicare program was on average 114% higher than traditional Medicare, the ACA changed some of the Medicare Advantage payment methodologies and began paying bonuses to plans that achieve certain quality metrics in 2012. Reductions in the Medicare Part C program may have an impact on reimbursement from these insurance plans, which in turn may have a material negative impact upon the revenue of Mayo Clinic and its affiliates. On April 6, 2015, CMS announced a 1.25% increase in Medicare Advantage plan rates for 2016.

**Audits, Exclusions, Fines and Enforcement Actions**. Hospitals participating in Medicare and Medicaid are subject to audits, withholding of payments, and retroactive audit adjustments under those programs. Based on an audit, a Medicare contractor may conclude that a patient discharge has been claimed under an incorrect MS-DRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to admission as an inpatient should not have been billed as outpatient services or that certain required procedures or processes were not satisfied. As a consequence, payments may be disallowed retroactively. Under certain circumstances, payments made may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act or other federal statutes, subjecting the hospital to civil or criminal sanctions.

The federal government uses a national recovery audit contractor ("RAC") program to identify overpayments and underpayments to providers under the Medicare program. The RAC auditors are compensated on a contingent fee basis. Mayo Clinic's experience during the pilot phases of the RAC

program found far more overpayments than underpayments. Medicare contractors will recoup RAC identified overpayments unless appeals are filed timely. RAC assessments against Mayo Clinic are anticipated; however, the outcome of such assessments are unknown and cannot be reasonably estimated. The ACA expands the scope of the RAC program to include Medicare Parts C and D and Medicaid.

In addition, under both the Medicare and Medicaid programs, certain health care providers, including hospitals, are required to report certain financial information on a periodic basis and with respect to certain types of classifications of information. Penalties are imposed for inaccurate reports. As these requirements are numerous, technical and complex, there can be no assurance that Mayo Clinic will avoid incurring such penalties in the future. These penalties may be material and adverse and could include administrative criminal or civil liability for making false statements or claims and/or an administrative action for exclusion from participation in the federal health care programs.

**Provider-Based Designation**. CMS regulations describe the criteria and procedures for determining whether a facility or organization is "provider-based" and thereby treated as part of a hospital campus (with often higher reimbursement levels for certain services), rather than as a freestanding entity. In the event that a Mayo facility or department that bills for outpatient services as a provider-based entity is found to be out of compliance with the current provider-based regulations, Mayo Clinic could be liable for Medicare overpayments.

**New Models of Care Delivery.** The ACA encourages the development of health care delivery models that are designed to enhance quality and reduce cost and that will effectively require greater integration between and collaboration among hospitals and physicians. One such program, the ACO program, allows participants that meet certain quality thresholds and other performance metrics to share in any savings achieved for the Medicare Program. Other programs include value based purchasing initiatives, which bases payment on certain patient outcomes. The outcomes of these new programs and the impact they will have upon the health care marketplace, is unknown and cannot be predicted.

**Medicaid Reimbursement**

Medicaid is a joint federal-state reimbursement program that is administered in each state by that state's health or public welfare agency. Medicaid programs vary from state to state. In each state's program, Medicaid generally pays for covered health care services provided to certain categorically qualified or indigent individuals. In many states, reimbursement for operating costs is based on the federal PPS and Medicaid reimburses hospitals a fixed amount based on the patient's diagnosis regardless of the actual costs incurred for treatment. The amount and method of reimbursement by Medicaid programs to acute care hospitals for outpatient services in states in which Mayo Clinic and its affiliates are located vary from state to state. Some states reimburse based on PPS, others on a percentage of usual and customary charges, and still others pay the lower of usual and customary charges or a fixed rate amount. Medicaid payments often may be inadequate to cover the cost of the care provided to beneficiaries. Each state's formula for reimbursement is subject to change and there can be no assurance that such payments will be adequate to cover the cost of care for the beneficiaries in the future. Pursuant to the Medicaid program, the federal government supplements funds provided by the various states for medical assistance to the medically indigent. Payment for such medical and health services is made to hospitals in an amount determined in accordance with procedures and standards established by state law under federal guidelines.

The ACA made several changes to the Medicaid program. The ACA gives states the option to expand Medicaid program eligibility to cover individuals with household income up to 133% of the FPL. The federal government is responsible for the cost of this coverage expansion in the initial years. Thereafter, each state will share in the financial burden of the expanded coverage. The ACA also

prohibits states from reimbursing certain providers for certain health-care acquired conditions or "provider preventable conditions" and requires states to implement policies to conform to this requirement. These changes and the Supreme Court decision regarding the constitutionality of the ACA makes it difficult to predict how many uninsured will be covered by the ACA Medicaid expansion program or to determine funding for providing care to the uninsured. Certain outcomes, such as a state refusing to expand Medicaid coverage while Medicaid payment cuts are implemented, could put providers at greater risk.

**Minnesota Health Care**

Minnesota abandoned its certificate of need program in 1971 and replaced it with a moratorium on new hospitals and hospital expansion. In 2004, the Minnesota legislature created a new process for seeking exceptions to the moratorium. A hospital seeking to increase its number of licensed beds or to obtain a new hospital license must submit a plan to the Commissioner of Minnesota Department of Health that demonstrates how the expansion will meet the public interest (a "Public Interest Review"). The Public Interest Review seeks to determine whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services; the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region; how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff; the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and the views of affected parties. After the Public Interest Review the Commissioner of Health will issue his or her findings. Authority to approve any exception to the hospital moratorium continues to rest with the legislature.

**Medical Assistance**. Medical Assistance is the Minnesota Medicaid program and provides health care coverage for children, families, people with disabilities and people age 65 or older who do not have income above certain thresholds and do not have assets valued over a certain amount. Medical Assistance is the state's largest publicly funded health care program. Under this program, enrollees do not have to pay premiums, although some enrollees may have small copays for certain services, and Medical Assistance covers most medical services. Minnesota expanded its Medicaid program under the ACA. Minnesota also operates several Medicaid waiver programs that increase coverage across various patient populations, including the elderly, the disabled and pregnant women.

**MinnesotaCare**. The Minnesota Department of Human Services administers MinnesotaCare, the state's subsidized health insurance program for those Minnesotans who lack access to affordable health care coverage. To qualify for MinnesotaCare, a person must have no access to affordable health insurance and must not have an annual income in excess of certain levels. While MinnesotaCare is partly funded by federal funding and enrollee premiums, which are determined by a sliding-fee scale based on family size and income, the majority of the program's funding is generated by a tax rate of two percent of certain revenues of health care providers, including hospitals, and one percent on premiums of nonprofit health plan companies. All persons enrolled in MinnesotaCare receive their care through managed care health plans, which pay a monthly capitation payment for each MinnesotaCare enrollee. Reimbursement under MinnesotaCare is based on Medicaid rates and there can be no guarantees that such rates adequately cover the cost of care for MinnesotaCare beneficiaries.

The MinnesotaCare Act sets forth various requirements to restrain the rate of growth in health care costs in Minnesota, including various reporting requirements applicable to participating health care providers such as Mayo Clinic and its Minnesota affiliates. Providers who fail to submit complete and timely expenditure reports for certain major spending commitments will risk the imposition of prospective review of and approval for major capital expenditures. Such matters, as well as more general

governmental budgetary concerns, may in the future reduce payments made to providers under the MinnesotaCare program.

**Future State Legislation**. From time to time, the Minnesota State Legislature considers certain reforms aimed at containing health care costs and increasing coverage. Ongoing state budget deficits may prompt cuts to state health care programs, which could result in the loss of affordable coverage or reimbursement cuts for participating providers. Reforms may also include provisions to provide more affordable coverage through expanded government health care programs, subsidize low income residents to enable them to purchase health care coverage and study and implement payment system reforms. At this time, it is impossible to measure the overall financial impact that current and future legislation, if enacted into law, would have on Mayo Clinic and its Minnesota affiliates.

**Florida Health Care**

In Florida, hospitals are regulated by the Florida Agency for Health Care Administration ("AHCA"). AHCA requires all health care facilities to file an application for a certificate of need for the new construction or establishment of additional health care facilities, including a replacement health care facility when the proposed project site is not located on the same site as or within one mile of the existing health care facility. There can be no assurances that an application for certificate of need approval of an action that requires certificate of need approval in fact will be approved by AHCA.

Florida non-profit law requires that licensed hospitals provide Medicaid and charity care, but does not specify acceptable levels of care. AHCA is responsible for Florida's Medicaid program. Inpatient services are currently reimbursed prospectively based on cost-reported, per diem rates. Florida has not expanded its Medicaid program under the ACA.

In 2011, the Florida legislature created the "Statewide Medicaid Managed Care" program, which is comprised of the Florida Long-Term Care Managed Care Program and the Florida Managed Medical Assistance Program. Medicaid recipients who qualify and become enrolled in the Florida Long-Term Care Managed Care Program will receive all of their long-term care services from a long-term care managed care plan. Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance Program will receive all of their health care services other than long-term care from a managed care plan. Both the Long-term Care Managed Care Program and the Managed Medical Assistance Program operate under separate Medicaid waivers. No assurances can be made regarding the availability of funds under the Florida Medicaid program or what affect the use of managed care providers will have on Medicaid reimbursement in the future.

In 2012 the Florida legislature mandated the conversion of the Medicaid hospital payment methodology for inpatient services from a per diem system to a Diagnosis Related Group (DRG) model. Outpatient services continue to be reimbursed on a per diem basis. AHCA unveiled its plan for conversion to the DRG system on January 7, 2013 and began implementation of DRG pricing on July 1, 2013. The effects of this conversion are currently being evaluated by Mayo Clinic but the conversion could have an adverse effect on its revenues.

In 2015 the Florida legislature considered and passed a number of changes affecting the health care sector, including providers such as Mayo Clinic. Senate Bill 2508-A became law with an effective date in July of 2015. Among other things, the bill changed the definition of "rural hospitals," which affects hospitals' abilities to participate in a financial assistance program under Medicaid; increased funding for graduate medical education programs in the state; changed the state's formula for calculating DSH payments under its Medicaid program; and created the Florida Health Insurance Affordability Exchange Program, a state-managed insurance exchanged aimed at addressing an affordability gap left

after introduction of the federally-managed insurance exchange under the ACA. Another bill, passed by the Florida Senate but rejected by its House of Representatives in 2015, would have expanded Florida's Medicaid program as allowed under the ACA. As is the case in many states, laws affecting healthcare in Florida remain areas of ongoing interest for the state legislature. The combined effects on Mayo Clinic of the laws discussed in this paragraph and any future legislation cannot be accurately predicted at this time.

**Arizona Health Care**

Under Arizona law, healthcare institutions are licensed by, and required to file proposed increases in rates and charges with, the Arizona Department of Health Services ("ADHS"). ADHS is not empowered to prevent a rate increase; however, no increase may become effective until ADHS review is completed or 60 days have elapsed since a proposed increase was filed. Various legislative and referendum proposals have been made in the past and may be made in the future to subject healthcare providers, including Mayo Clinic Arizona, to rate regulations. Enactment of such proposals could adversely affect Mayo Clinic Arizona.

The Arizona Health Care Cost Containment System ("AHCCCS") is Arizona's alternative to the Medicaid program. AHCCCS operates under a waiver from the federal government, which expires on September 30, 2016, allowing it to mandate a managed care program and extend coverage to expanded populations. Arizona has expanded Medicaid under the ACA. In September 2015, Governor Ducey submitted a new demonstration waiver to CMS proposing changes to AHCCCS, including system reforms aimed to increase efficiency, stepped-up wellness and prevention incentives and expanded private-sector partnerships. A decision by CMS is expected by October 1, 2016.

There can be no assurances that payments under AHCCCS will be sufficient to cover the costs of treating Medicaid patients in the future or that Medicaid funding will be available in the future in Arizona.

**Georgia Health Care**

The Georgia Department of Community Health ("DCH") administers the Medicaid program to eligible residents. Georgia's Medicaid program has included a managed care program called Georgia Families since 2006, under which much of Georgia's Medicaid population is insured through private managed care plans under contract with the state government. However, the program does not cover Georgia's aged, blind, disabled or nursing home Medicaid population. As has been discussed elsewhere regarding managed care systems for health insurance there can be no guarantee that managed care payments will cover the full cost of care provided to patients. Additionally, there can be no guarantee that managed care programs will not be expanded to cover the aged, blind, disabled and nursing home Medicaid populations in Georgia, which could adversely affect the revenues of Mayo Clinic. Georgia also operates several Medicaid waiver programs, many of which allow certain Medicaid recipients to receive their care at home or in community based settings. Georgia has thus far elected not to participate in the expansion of Medicaid available under the ACA.

Georgia operates a Certificate of Need program, which requires hospitals to obtain state approval before any expansion, renovation, the offering of certain new service lines and the purchase of certain medical equipment that exceeds set thresholds. There can be no guarantee that Mayo Clinic will obtain Certificates of Need necessary to carry out its desired future plans for facilities and lines of service in Georgia, which could have an adverse effect on its business operations in that state.

**Wisconsin Health Care**

In Wisconsin, hospitals are licensed and regulated by the Wisconsin Department of Health Services ("DHS"). Wisconsin no longer has a certificate of need program for hospitals.

ForwardHealth is Wisconsin's Medicaid program, which is overseen by DHS. There are two main programs offered by ForwardHealth: the Medicaid plans for Elderly, Blind or Disabled ("EBD") and BadgerCare Plus. Under the Medicaid program's federal rules, the state's share of funding can come from a number of sources, including recipient premiums, provider taxes, certified public expenditures and other funding transfers. In January 2014, Wisconsin received approval from CMS of a Medicaid waiver for BadgerCare Plus. The waiver, which went into effect April 1, 2014, provides BadgerCare Plus coverage for childless adults with incomes up to 100% of the FPL who are not otherwise eligible for BadgerCare Plus for Families or Medicaid and are not entitled to Medicare, and requires all parents and caretaker relatives who qualify for transitional medical assistance to pay a monthly premium. The waiver also eliminated the BadgerCare Plus Core Plan, removed the enrollment cap for childless adults with incomes under 100% of the FPL, and provided all BadgerCare Plus members with Standard Benefit plans. Wisconsin has not expanded Medicaid under the ACA.

**State Children's Health Insurance Program**

The Children's Health Insurance Program ("CHIP") provides federal matching funds to states that cover 65% to 84% of the costs of health care coverage, primarily for low-income children. CMS administers CHIP, but each state creates its own program based on minimum federal guidelines, or the state may apply for a waiver, which allows the state to create its own program using the federal funds, but often with different criteria for eligibility. The states in which Mayo Clinic operates have a variety of CHIP programs and waiver programs;

- Minnesota operates its CHIP program as an expansion of the Medicaid program. Families with children under the age of 2 whose incomes up to 283% of the FPL and families with children between the ages of 6 and 18 with incomes up to 275% of the FPL are eligible for Medical Assistance. Families who are not eligible for Medical Assistance and whose income is up to 200% of the FPL are eligible for MinnesotaCare.

- Arizona froze enrollment its CHIP program, known as Kids Care, effective June 15, 2010 due to lack of funding for the program. The Kids Care II program, which was established in 2012 as a safety net care pool under AHCCCS to cover children whose family income was at or below 175% of the FPL, expired January 31, 2014.

- Florida's CHIP program, Florida KidCare, through a variety of component programs, covers children whose family income is less than 200% of the FPL and who are not eligible under the traditional Medicaid program.

- Georgia's CHIP program, PeachCare for Kids, is a comprehensive health care plan available to children in families with income at or below 247% of the FPL. The program provides coverage for a range of services including well care, hospitalization, vision and dental coverage for uninsured children until the age of 18. The child's care is coordinated by a managed care organization. Beginning on January 1, 2012, state employees were eligible to enroll their children in PeachCare for Kids.

- Wisconsin obtained a waiver from the federal government in 2008 effective through December 31, 2018, and created BadgerCare Plus, a managed care delivery system for

low income children with household income at or below 300% of the FPL and certain adults at or below 100% of the FPL, funded by the CHIP and Medicaid programs. Wisconsin uses federal funds to cover individuals and children that meet the required FPL guidelines, and state funds to cover all other uninsured children.

On May 26, 2015, CMS released a proposed rule to modernize and enhance the provision of quality care to Medicaid managed care and CHIP beneficiaries. This proposed regulation is the first significant update to the Medicaid and CHIP managed care regulations in over 10 years. Several of the most important provisions of the proposed rule relate to making beneficiary communications and access better and easier, encouraging state endeavors to deliver higher quality care in an economical way, setting forth quality improvement mechanisms, clarifying actuarial soundness requirements, and aligning standards with other sources of health insurance coverage. It is uncertain to what extent and in what form the provisions of this proposed regulation will be finalized and what impact such finalized rules will have on Mayo Clinic.

While CHIP is generally considered to be beneficial for both patients and providers because it reduces the number of uninsured children, it is difficult to assess the fiscal impact of CHIP payments on Mayo Clinic and its affiliates. Moreover, each state must periodically submit its CHIP plan to CMS for review to determine if it meets the federal requirements. If a state does not meet the federal requirements, it may lose its federal funding for its program. From time to time Congress and/or the President seek to expand or contract CHIP. MACRA extends CHIP through September 30, 2017. The loss of federal approval for a state's program or a reduction in the amounts available under SCHIP could have an adverse impact on the financial condition of Mayo Clinic and its affiliates.

**Third-Party Reimbursement**

A significant portion of the net patient service revenue of Mayo Clinic and its affiliates is received from commercial third-party payors and other non-governmental agencies, which provide third-party reimbursement for patient care on the basis of various formulae. Renegotiations of such formulae and changes in such reimbursement systems may reduce such third-party reimbursements to Mayo Clinic and its affiliates. The reimbursement currently paid by third parties is likely to be subject to more restrictions in the future, and there can be no assurance that such payments will be adequate to cover the cost of care for the beneficiaries in the future. In addition, contracts between hospitals and third-party payers often have contractual audit, setoff and withhold language that may cause substantial retroactive adjustments. Such contractual adjustments also could have a material adverse effect on the financial condition and results of operations of Mayo Clinic.

The ACA includes insurance market reforms that, among other things, require individual and group health insurance plans to offer coverage (including renewability) on a guaranteed basis. The ACA prohibits pre-existing condition limitations, certain coverage limitations, lifetime and annual dollar limits for essential health benefits, and requires coverage of certain preventive health benefits. The ACA requires every individual to enroll in a health plan through an employer, a federal government health program such as Medicare, Medicaid or Tricare (the health care plan for military personnel), or purchase insurance through a health insurance exchange established by each state. Individuals who do not enroll for coverage, and large employers who do not offer affordable and adequate coverage, will be subject to tax penalties. It is unclear at this time whether the tax penalties will result in substantial compliance with the mandate to obtain insurance. It is also unclear at this time what long-term effects the ACA's insurance reforms will have on the financial condition of providers such as Mayo Clinic.

The ACA establishes the criteria for new Qualified Health Plans ("QHPs") that may participate in the state run exchanges. A QHP must meet certain minimum essential coverage requirements. Minimum

essential coverage requirements may be offered at one of four levels of coverage: bronze, silver, gold or platinum. Each QHP must agree to offer at least one plan at the silver and gold level. The ACA sets forth the minimum coverage offered under each plan level and limits the variations in premiums that may be charged for exchange coverage on the basis of age and tobacco use. A QHP must also be certified by each exchange through which the plan is offered, must be licensed in each state where it offers insurance, and the QHP must limit cost sharing with the insured.

Under the ACA, individuals with family income under 400% of the FPL will be eligible for subsidized premiums, deductibles and co-pays for exchange plan coverage. Initially, only individuals and small employers will be able to access coverage through the exchanges. By 2017, large employers also will be able to use the exchanges to provide employer-based coverage to their employees. Although existing health insurance plans may continue to offer coverage as grandfathered plans in the individual and group markets, enrollment in such plans will be limited to those who were currently enrolled and their families. New employees and their families still will be allowed to enroll in grandfathered employer-sponsored coverage. At this time, it is not possible to project what impact the exchanges will have on competition in the insurance markets, the cost of coverage for employers, reimbursement rates for hospitals and physicians or the number of uninsured patients that Mayo Clinic will still need to treat.

Currently, most private insurance companies contract with hospitals on an exclusive or preferred-provider basis, and some insurers use plans known as preferred provider organizations ("PPOs"). Under these plans, there may be financial incentives for subscribers to use only those hospitals and physicians who contract with those plans. Under an exclusive provider plan, an arrangement that includes most health maintenance organizations ("HMOs"), private payors limit coverage to those services provided by network hospitals and physicians. With this contracting authority, private payors may direct patients away from hospitals not in the network by denying coverage for services provided by them.

Currently, most PPOs and HMOs pay hospitals on a discounted fee-for-service basis or on a discounted fixed rate per day of care. The discounts offered to HMOs and PPOs may result in payment at less than actual cost, and the volume of patients directed to a hospital under an HMO or PPO contract may vary significantly from projections. Therefore, the financial consequences of such arrangements cannot be predicted with certainty and may be different from current or prior experience. Some HMOs offer or mandate a "capitation" payment method under which hospitals are paid a predetermined periodic rate for each enrollee in the HMO who is "assigned" to, or otherwise directed to receive care at, a particular hospital. In a capitation payment system, the hospital assumes an insurance risk for the cost and scope of care given to the HMO's enrollees. If payment under an HMO or PPO contract is insufficient to meet the hospital's costs of care, or if use by enrollees materially exceeds projections, the financial condition of that hospital may be adversely affected.

HMOs and other third-party payors that contract on a discounted fee-for-service or discounted fixed rate-per-day basis also exert strong controls over the utilization of health care resources. Strong utilization management by managed care plans has led to reduction in the number of hospitalizations and lengths of hospital stays, both of which may reduce patient service revenue to hospitals. Furthermore, shortened hospital lengths of stay have not necessarily been accompanied with a reduced demand for services while a patient is hospitalized and in fact may lead to more intensive hospital visits and correspondingly increased costs to hospital providers.

Mayo Clinic and its affiliates also may be affected by the financial instability of HMOs and other third-party payors from which it receives reimbursement for furnishing health care services. For example, if regulators place a financially-troubled HMO into rehabilitation under state law, or if a third-party payor files for protection under the federal bankruptcy laws, it is unlikely that health care providers will be reimbursed in full for services furnished to enrollees of the HMO or the third-party payor. Health care

providers also may be required by law or court order to continue furnishing health care services to the enrollees of an insolvent HMO or third-party payor, even though the providers may not be reimbursed in full for such services.

Employer-sponsored health insurance plans are adopting health care benefits that create incentives for employees to participate in preventative care programs and better manage chronic diseases. These programs may reduce the costs of providing health care benefits and help maintain a healthier workforce. Employers also are adding alternatives to traditional fee for service health insurance programs, by offering a variety of health insurance programs that increase cost sharing by employees or reduce cost by limiting access to only preferred providers. These types of insurance programs are expected to cover an increasing share of health care services being provided in the future.

Per diem rates, other risk-based payment systems and discounts pose major challenges to hospital providers. In order to enter into such contracts, hospitals not only must anticipate the cost of rendering specific services to patients, but also estimate the likelihood and severity of illness or injury within the population which the hospital serves. If payment under a managed care plan contract is insufficient to meet a hospital's costs of caring for the needs of the population it serves, that hospital's financial condition may erode rapidly and significantly. Often, managed care plan contracts are enforceable for the stated term, regardless of provider losses. Furthermore, managed care plan contracts and insurance laws may require that a hospital continue to provide care for enrollees for a certain period of time irrespective of whether the managed care plan has funds to make payment to the hospital.

Increasingly, physician practice groups, independent practice associations and other physician management companies have become a part of the process of negotiating payment rates to hospitals by managed care plans. This involvement has taken many forms but typically increases the competition for limited payment resources from managed care plans. For example, it is increasingly common for managed care plans to enter into contracts with physicians that may give physicians incentives in patient care decisions which may result in reduced hospital admissions and procedures.

Any new payment methods implemented by the Medicare and Medicaid programs in response to the ACA provisions are likely to drive similar changes in the private payor market. Programs designed to encourage coordination of care, value-based purchasing and quality outcomes will likely evolve in the private payor market.

There is no assurance that reimbursement contracts of Mayo Clinic, its affiliates or their physicians with Blue Cross, HMOs, PPOs or other third-party payors will be maintained, that other similar contracts will be obtained in the future, or that payments from such payors will be sufficient to cover all of the costs Mayo Clinic and its affiliates incur in providing services to their beneficiaries. Failure to execute and maintain such contracts could have the effect of reducing the patient base or health care revenues of Mayo Clinic and its affiliates. Conversely, participation may maintain or increase the patient base, but may result in reduced payments.

Additionally, major purchasers of health care services could take action to restrict hospital charges or charge increases. As a result of increased public scrutiny, it is also possible that the pricing strategies of health care providers may be perceived negatively by consumers and health care providers may be forced to reduce fees for their services. Decreased utilization could result, and health care providers' revenues may be negatively impacted. In addition, consumers and groups lobbying on behalf of consumers are increasing pressure for health plans, hospitals and other health care providers to be transparent and provide information about cost and quality of services that may affect future consumer choices about where to receive health care services.

**Uncompensated Care**

Although Mayo Clinic attempts to assure payment or reimbursement for most of the care it renders, it provides a substantial amount of uncompensated care to indigents. Obligations to provide uncompensated care can arise from laws and regulations that may require Mayo Clinic to provide care without regard to a patient's ability to pay for such care. Increased unemployment or other adverse economic conditions could increase the proportion of patients who are unable to pay all or any of the costs of their care.

Lawsuits have been filed in both federal and state courts alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. The cases are proceeding in various courts around the country with inconsistent results. While it is not possible to make general predictions, some hospitals and health systems have incurred substantial costs in defending such lawsuits and in some cases have entered into substantial settlements. Mayo Clinic is not currently a defendant in litigation matters involving claims such as those described in the preceding two paragraphs.

In addition, the Minnesota Attorney General has conducted a number of reviews of the policies and practices of Minnesota hospitals with regard to their provision of charity care and their collection practices. As a result of those audits, most hospitals in Minnesota, including hospitals within the Mayo Clinic, have agreed to follow certain policies and practices with regard to charity care, discounts for self-pay members and collections. The agreements provide that the hospital must limit the amounts charged for medically necessary care to uninsured individuals to not more than the hospital would be reimbursed for that service by the insurance company providing the hospital with the most revenue in the previous calendar year and that the hospital must not engage in certain collection actions until a debt is authorized by an accountable employee of the hospital upon verification of certain information.

While the ACA should reduce uncompensated care by expanding health care coverage to a larger portion of the population, its effects on coverage and access continue to evolve and cannot be accurately predicted for the future. In addition, the Medicaid program is dependent on the continued availability of federal and state funding, which could be curtailed in the future in response to growing budget deficits at all governmental levels. The continued availability, comprehensiveness of coverage and adequacy of reimbursement for care for the indigent and disabled cannot be assured in the future.

**Regulatory Environment**

Mayo Clinic, its affiliates and the health care industry in general are subject to regulation by a number of governmental agencies, including those that administer the Medicare and Medicaid programs, federal, state and local agencies responsible for administration of health care planning programs, and other federal, state and local governmental agencies. These laws and regulations also require hospitals to meet various detailed standards relating to the adequacy of medical care, equipment, personnel, information technology, patient confidentiality, operating policies and procedures, maintenance of adequate records, utilization, rate setting, compliance with building codes and environmental protection laws, and numerous other matters. Failure to comply with applicable regulations can jeopardize a hospital's licenses, its ability to participate in the Medicare and Medicaid programs, and its ability to operate as a hospital. These laws and regulations, as well as similar laws and regulations now in effect, and the adoption of additional laws and regulations in these and other areas could have an adverse effect on Mayo Clinic's ability to generate revenues in sufficient amounts to timely pay the Bonds.

Some of these legislative and regulatory changes are discussed below.

**Federal False Claims Act and Civil Monetary Penalties Law**. There are multiple federal laws covering the submission of inaccurate or fraudulent claims for reimbursement and errors or misrepresentations on cost reports by hospitals and other health care providers. The coding, billing and reporting obligations of Medicare providers are extensive, complex and highly technical. In some cases, errors and omissions by billing and reporting personnel may result in liability under one of the federal False Claims Act or similar laws, exposing a health care provider to civil and criminal monetary penalties, as well as exclusion from participation in the Medicare and Medicaid programs.

The federal False Claims Act prohibits (1) knowingly submitting a false or fraudulent claim for payment to the United States; (2) knowingly making, using or causing to be made or used a false record or statement to obtain payment from the United States; or (3) engaging in a conspiracy to defraud the federal government by getting a false or fraudulent claim allowed or paid. This statute is violated if a person acts with actual knowledge, or in deliberate ignorance or reckless disregard of the falsity of the claim. Penalties under the False Claims Act include fines of up to $11,000 per claim, plus treble damages, potentially resulting in penalties aggregating millions of dollars for ongoing claims submission errors. Anyone who knowingly makes a false statement or representation in any claim to the Medicare or Medicaid programs may be subject to criminal penalties, including fines and imprisonment.

The False Claims Act includes "whistleblower" provisions under which a person who believes that someone is violating the False Claims Act can file a sealed complaint against the alleged violator in the name of the United States government. The nature of the allegations is not revealed to the target during the time the United States Justice Department investigates the complaint and determines whether to join in the suit. If the Justice Department decides not to join in the suit, the original whistleblower nonetheless can proceed. If the case is successful, the whistleblower is entitled to between 15% and 30% of the proceeds of any fines or damages paid. Although the False Claims Act has been in effect for many years, in recent years there has been a significant increase in the number of whistleblower allegations filed under the False Claims Act, a large number of which involve the health care and pharmaceutical industries. In 2009, President Obama signed into law the Fraud Enforcement Recovery Act which authorized increased funding for fraud investigation and prosecution, and expanded the scope of the False Claims Act to impose liability for false claims with more remote connections to the federal government.

The ACA requires a person who receives an overpayment to report and repay the overpayment within 60 days after the overpayment is identified or the date any corresponding cost report is due, whichever is later. The ACA defines overpayments as "any funds that a person receives or retains under Medicare or Medicaid to which the person, after applicable reconciliation, is not entitled." Failure to repay any overpayment within the deadline could lead to liability under the False Claims Act.

In addition, the Civil Monetary Penalties Law under the Social Security Act (the "CMP Law") provides for the imposition of civil money penalties against an entity that engages in activities including, but not limited to, (a) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (b) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (c) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (d) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (e) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; (f) using a payment intended for a federal health care program beneficiary for another use; (g) the practice or pattern of presenting a claim for an item or service on a reimbursement code that the person knows or should know will result in greater payment than appropriate, i.e., upcoding; and (h) engaging in a practice of submitting claims for payment for medically unnecessary services. Penalties under the CMP Law include up to

$50,000 for each item or service claimed, and damages of up to three times the amount claimed for each item or service, and exclusion from participation in the federal health care programs.

The threats of large monetary penalties and exclusion from participation in Medicare, Medicaid and other federal health care programs, and the significant costs of mounting a defense, create serious pressures on providers who are targets of false claims actions or investigations to settle. Therefore, an action under the False Claims Act or the CMP Law could have an adverse financial impact on Mayo Clinic and its affiliates, regardless of the merits of the case.

Many states, such as Minnesota, have enacted their own version of a false claims act, which covers claims for payment made under state healthcare programs. An action under any state false claims act also could have an adverse financial impact on Mayo Clinic and its affiliates.

**"Fraud and Abuse" Laws and Regulations**. The federal Medicare/Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act (known as the "Anti-Kickback Law") prohibit the knowing and willful offer, payment or receipt of remuneration in exchange for or as an inducement to make or influence a referral of a patient for the provision of goods or services that may be reimbursed under federal health benefit programs. The scope of the Anti-Kickback Law is very broad, and it potentially implicates many practices and arrangements common in the health care industry, including space and equipment leases, personal services contracts, purchase of physician practices, joint ventures, and relationships with vendors. Penalties for violation of the Anti-Kickback Law include criminal prosecution, criminal fines of up to $25,000, civil penalties of up to $50,000 per violation, as well as exclusion from the federal health care programs.

The ACA amended the intent requirement to provide that a person need not have actual knowledge of the Anti-Kickback law or specific intent to commit a kickback violation, to violate the statute. Penalties for the failure to grant timely access to HHS were also added by the ACA.

Federal statutory exceptions and "safe harbor" regulations describe certain arrangements that will not be deemed to violate the Anti-Kickback Law. However, the exceptions and safe harbors are narrow and do not cover a wide range of economic relationships that many hospitals, physicians and other health care providers historically have considered to be legitimate business arrangements not prohibited by the Anti-Kickback Law. Because the exceptions and safe harbor regulations do not purport to describe comprehensively all lawful or unlawful economic arrangements or other relationships between health care providers and referral sources, it is uncertain whether hospitals, physicians and other health care providers that have these arrangements or relationships may need to alter them in order to ensure compliance with the Anti-Kickback Law. Failure to comply with an exception or safe harbor does not mean an arrangement necessarily violates the Anti-Kickback Law. However, failure to do so may increase the likelihood of a regulatory challenge or the potential for investigation.

Although the Anti-Kickback Law applies only to health benefit programs funded by the federal government, a number of states have passed similar laws pursuant to which similar types of prohibitions are made applicable to other health plans or third-party payors. For example, Minnesota has a provider conflicts of interest law in Minnesota Statutes Chapter 621, which is modeled after the federal Anti-Kickback law.

Because the safe harbor exceptions are narrowly drawn and the case law interpreting the Anti-Kickback Law is sparse, there can be no assurances that Mayo Clinic or its affiliates will not be found to be in violation of the Anti-Kickback Law. If such a violation were found, any sanctions imposed could have a material adverse effect upon the future operations and financial condition of Mayo Clinic and its affiliates.

**Restrictions on Self-Referrals**. The federal Ethics in Patient Referrals Act (known as the "Stark Law") prohibits a physician who has a financial relationship, or whose immediate family member has a financial relationship, with an entity that provides certain designated health services from referring Medicare patients to that entity for the provision of such designated health services, with limited exceptions. The Stark Law designated health services include physical therapy services, occupational therapy services, radiology or other diagnostic services (including MRIs, CT scans and ultrasound procedures), durable medical equipment, radiation therapy services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, and inpatient, outpatient hospital services, clinical laboratory services and diagnostic and therapeutic nuclear medicine services. The Stark Law also prohibits an entity that receives a prohibited referral from filing a claim or billing for the services arising out of that prohibited referral.

There are certain exceptions to the Stark Law, based on the nature of the financial relationship between the referring physician and the entity. Unlike the Anti-Kickback Law, the Stark Law is not an intent based statute. No wrongful intent or culpable conduct is required for violation of the Stark Law. When a financial relationship exists between an entity and a physician, the arrangement must meet the necessary elements of a Stark Law exception in order for a referral to be made for designated health services to that entity and for that entity to bill for those designated health services generated by the referral. Sanctions under the Stark law include denial and refund of payments, civil monetary penalties of up to $15,000 for each service arising out of the prohibited referral, a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law's prohibition, and exclusions from the Medicare and Medicaid programs. Also, because the Stark law is a Medicare payment rule, claims prohibited by the Stark law may also be the predicate for liability under the False Claims Act.

In 2010, as required under the ACA, CMS released a protocol under which health care providers can make self-disclosures of actual and potential Stark violations, with reduced penalties for self-disclosed violations.

Although the Stark Law only applies to Medicare, a number of states (including Minnesota) have passed similar statutes pursuant to which similar types of prohibitions are made applicable to all other health plans or third-party payors. Minnesota law provides an exception for referrals made to designated health services when the physician has disclosed a financial or economic interest to the patient. Minnesota law also provides that the Commissioner on Health may audit the referral patterns of providers that qualify for Stark Law exceptions and requires the Commissioner to report to the state legislature any audit results that reveal a pattern of referrals by a provider for the furnishing of health services to an entity with which the provider has a financial relationship. This audit authority extends to all health care services rather than just Stark Law designated health services. In 2004, the Minnesota Legislature enacted a statute requiring patients to be informed in writing prior to receiving a referral to a hospital, outpatient surgical center, diagnostic imaging facility or any affiliates thereof, if the referring provider has an economic interest or an employment or contractual arrangement with such facility. In addition, a written notice of the relationship must be posted in a conspicuous public location within the provider's facility.

Because of the complexity of the Stark Law and the evolving nature of quality improvement and cost-reduction efforts, there can be no assurances that Mayo Clinic and its affiliates will not be found to have violated the Stark Law or the state law equivalent. If such violation were found to have occurred, any sanctions imposed could have a material adverse effect upon the future operations and financial condition of Mayo Clinic and its affiliates. Additionally, amendments to regulations promulgated under the Stark Law may require Mayo Clinic to amend or terminate certain arrangements with physicians to comply with new regulatory requirements.

**HIPAA**. Congress enacted The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as part of a broad health care reform effort. Among other things, HIPAA established a program administered jointly by the Secretary of HHS and the United States Attorney General designed to coordinate federal, state and local law enforcement programs to control fraud and abuse in connection with the federal health care programs. In addition, Congress greatly increased funding for health care fraud enforcement activity, enabling the OIG to substantially expand its investigative staff and authorizing the Federal Bureau of Investigation to quadruple the number of agents assigned to health care fraud. The result has been a dramatic increase in the number of civil, criminal and administrative prosecutions for alleged violations of the laws relating to payment under the federal health care programs, including the Anti-Kickback Law and the False Claims Act. This expanded enforcement activity, together with the whistleblower provisions of the False Claims Act, has significantly increased the likelihood that health care providers, including Mayo Clinic and its affiliates, could face inquiries or investigations concerning compliance with the many laws governing claims for payment and cost reporting under the federal health care programs.

In addition to the expanded enforcement activity noted above, the "Administrative Simplification" provisions of HIPAA mandate the use of uniform standard electronic formats for certain administrative and financial health care transactions, the adoption of minimum security standards for individually identifiable health information maintained or transmitted electronically, and compliance with privacy standards adopted to protect the confidentiality of personal health information. The Administrative Simplification provisions apply to health care providers, health plans, and health care clearinghouses, and their agents and subcontractors referred to as Business Associates (collectively "Covered Entities"). Use and disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of HIPAA and related regulations or authorized by the patient. HIPAA's privacy and security provisions extend not only to patient medical records but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose new communication. operational accounting and billing restrictions. These restrictions add costs and create potentially unanticipated sources of legal liability.

On January 25, 2013, HHS issued comprehensive modifications to the existing HIPAA regulations to implement the requirements of the HITECH Act (see below for more on the HITECH Act), commonly known as the "HIPAA Omnibus Rule." The HIPAA Omnibus Rule became effective on March 26, 2013, and covered entities were required to be in compliance by September 23, 2013 (though certain requirements have a longer timeframe), Key aspects of the HIPAA Omnibus Rule include but are not limited to: (i) a new standard for what constitutes a breach of protected health information,(ii) establishing four levels of culpability with respect to civil monetary penalties assessed for HIPAA violations, (iii) direct liability of business associates for certain violations of HIPAA, (iv) modifications to the rules governing research, (v) stricter requirements regarding non-exempt marketing practices, (vi) modification and re-distribution of notices of privacy practices, and (vii) stricter requirements regarding the protection of genetic information. While the effects of the HIPAA Omnibus Rule cannot be predicted at this time, the obligations imposed thereunder could have a material adverse effect on the financial condition of the Mayo Clinic.

**The HITECH Act.** The American Recovery and Reinvestment Act of 2009 ("ARRA"), which includes the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), appropriated approximately $20 billion for the development and implementation of health information technology ("HIT") standards and the adoption of electronic health care records. The HIT infrastructure is intended to improve health care quality, reduce health care costs and facilitate access to necessary information. Among other things, the HITECH Act provides financial incentives (through the Medicaid and Medicare programs) as well as loans and grants to encourage practitioners and providers to engage in "meaningful use" of electronic health record ("EHR") technology. Health care providers demonstrate

their meaningful use of EHR technology by meeting objectives specified by CMS for using HIT and by reporting on specified clinical quality measures. Medicare payments are significantly reduced for hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use. Under a revised schedule, Stage 2 of the EHR incentive program was extended through 2016 and Stage 3 will begin in 2017 for providers having completed at least two years in Stage 2. CMS issued proposed rules for Stage 3 of the EHR incentive program on March 30, 2015. Final regulations have not yet been issued. Additionally, beginning with attestations submitted during and after January 2013, the federal government began auditing hospitals' and providers' records related to their attestation of being "meaningful users" in order to obtain the incentive payments. A hospital or provider that fails the audit will have an opportunity to appeal. Ultimately, hospitals or providers that fail on appeal will have to repay any incentive payments they received through these programs.

ARRA also significantly expanded the HIPAA privacy and security provisions applicable to Covered Entities and their business associates. The law provides that individuals be notified when there is a breach of their unsecured electronic personal health information, increases civil monetary and criminal penalties for HIPAA violations, and authorizes the state attorneys general to enforce its provisions. Each Covered Entity must report any breach involving over 500 individuals in a state to HHS and the local media. All other breaches must be reported annually to HHS. The financial costs of continuing compliance with HIPAA and the Administrative Simplification regulations are substantial and will increase as a result of the ARRA amendments. The HITECH Act also limits a Covered Entity's discretion in determining what health care information about a person may be properly disclosed under the HIPAA privacy regulations.

Covered Entities that use an EHR are required to account for disclosures of information that are currently not subject to the accounting requirements, including disclosures for treatment, payment and health care operations. In addition, if a Covered Entity maintains an EHR, individuals have a right to receive a copy of the protected health information maintained in the record in an electronic format. Again, the Secretary of HHS is charged with developing guidance and implementing regulations for these requirements.

The HITECH Act includes provisions requiring Covered Entities to agree to a patient request to restrict disclosure of information to a health plan, if the information pertains solely to an item or service for which the provider was paid out of pocket in full. The HITECH Act also includes a prohibition on the payment or receipt of remuneration in exchange for protected health information without specific patient authorization, except in limited circumstances, and places additional restrictions on the use and disclosures of protected health information for marketing communications and fundraising communications.

In the event of an unauthorized disclosure of protected health information, Covered Entities now are required to notify the affected individuals, HHS and sometimes the media of the unauthorized disclosure, depending on the nature of the breach, the type of unauthorized disclosure and its scope.

The HITECH Act revises the civil monetary penalties associated with violations of HIPAA, and provides state attorneys general with authority to enforce the HIPAA privacy and security regulations in some cases, through a damages assessment of $100 per violation or an injunction against the violator. The revised civil monetary penalties range: (a) in the case of violations due to willful neglect, from a minimum of $10,000 or $50,000 per violation depending on whether the violation was corrected within 30 days of the date the violator knew or should have known of the violation, and (b) in the case of all other violations, from a minimum of $100 to $1,000 per violation. Recent settlements of HIPAA violations for breaches involving lost data have reached the millions of dollars. While there is currently

no private cause of action for violations of HIPAA or the HITECH Act, an individual may have a right to sue based on state law.

ARRA mandated that the Office of Civil Rights ("OCR") of HHS perform periodic audits to ensure covered entities and business associates are complying with the HIPAA Privacy and Security Rules and Breach Notification standards. To implement this mandate, OCR piloted a program to perform 115 audits of covered entities to assess privacy and security compliance. Audits conducted during the pilot phase began November 2011 and concluded in December 2012. OCR will be conducting "Phase 2" audits of both covered entities and business associates. Phase 2 was initially scheduled to begin in the fall of 2014, but its initiation has been postponed. Phase 2 will focus on areas of greater risk to the security of protected health information and on pervasive non-compliance based on OCR's initial audit findings and observations, rather than a comprehensive review of all of the HIPAA Standards. Covered entities and their business associates can expect continued audit activity by OCR in the future.

Mayo Clinic is actively engaged in continuing compliance efforts with HIPAA and HITECH regulations. However, no guarantee can be made that Mayo Clinic will remain HIPAA compliant in the future.

**Physician Recruitment and Service Agreements.** The IRS, CMS and OIG have issued various pronouncements that could limit physician service, recruiting and retention arrangements. In IRS Revenue Ruling 97-21, the IRS ruled that a tax-exempt hospital that provides recruiting and retention incentives to a physician in order to have the physician join the hospital's medical staff or provide services to members of the community but not necessarily for or on behalf of the hospital itself risks loss of tax-exempt status unless the incentives are reasonably necessary to address a community need and accordingly provide a community benefit; improvement of a charitable hospital's financial condition does not necessarily constitute such a purpose. With respect to physician service contracts, the IRS takes the position that the compensation paid must be consistent with the value of services actually provided by the physician. The OIG also has taken the position that any arrangement between a federal health care program-certified facility and a physician that is intended even in part to encourage the physician to refer patients may violate the federal Anti-Kickback Statute unless a regulatory exception applies. Physician service recruitment and retention arrangements may also implicate the Stark Law. While the OIG has promulgated a practitioner recruitment safe harbor to the Anti-Kickback Statute, it is limited to recruitment in areas that are health professional shortage areas ("HPSAs"). OIG also requires consistency with fair market value for certain other exceptions that may apply to service contracts and may allege that any amount paid above fair market value implies an intent to induce referrals. The Stark Law exception for practitioner recruitment is not limited to HPSAs; rather it applies to the recruitment of physicians who are relocating their practices to the geographic area served by the hospital, if certain requirements are met. The Stark Law also contains an exception pertaining to retention arrangements that allows hospitals, in limited circumstances, to pay incentives to retain a physician in underserved areas. In addition, the Stark Law includes certain exceptions that may apply to service contracts with physicians or physician groups, many of which also require (among other things) that payments to the physician are consistent with fair market value for services actually performed. Arrangements with employed physicians are also covered by an Anti-Kickback Statute safe harbor, which protects any amount paid by an employer to a bona fide employee, and by an exception to the Stark Law which generally requires that amounts paid to a physician employee be consistent with fair market value of the services provided.

The sanctions which could be imposed by the IRS or the other regulatory authorities or the courts for violations of IRS regulations, the Stark Law and the Anti-Kickback Statute and for false claims under the federal FCA and other similar federal or state laws include, among other things, the loss of tax-exempt status of one or more Mayo Clinic entities, repayment of up to three times the amount of claim payments related to services provided or referred by affected physicians, exclusion of one or more Mayo Clinic

entities from federal health care programs, including the Medicare and Medicaid programs and/or additional monetary penalties.

Management of Mayo Clinic believes that its arrangements with employed and independent physicians are in material compliance with these laws and regulations, but no assurance can be given that regulatory authorities will not take a contrary position or that Mayo Clinic will not be found to have violated applicable law or that future laws regulations or policies will not have a material adverse impact on the ability of Mayo Clinic to recruit and retain physicians.

Physician recruitment may also be affected by a variety of other factors. For example physician recruitment in rural areas can be difficult and practice areas such as family medicine are in critical demand. It is common to take up to three years to fill positions in rural areas and because in many cases these areas already utilize large numbers of advanced practice clinicians (e.g., nurse practitioners and physician assistants) it is difficult to meet health care needs through more utilization of such professionals. Urban areas also face a short supply of certain physician specialties, such as pediatric psychiatry. Physician recruitment in behavioral health and certain subspecialties (developmental pediatrics and neuro-ophthalmology) is also challenging. Mayo Clinic is affected by these national trends.

**Coding Update**. The International Classification of Diseases (ICD) is the international standard diagnostic classification used for health management purposes, clinical use and billing. HHS mandated a change from ICD-9 coding standards to ICD-10 standards effective October 1, 2015. These changes may be costly to physicians and hospitals and will require significant planning, training and updates to the software and systems of hospitals at substantial cost to the hospitals and providers.

**Emergency Medical Treatment and Active Labor Act**. Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"), in response to allegations of inappropriate hospital transfers of indigent and uninsured emergency patients. EMTALA imposes strict requirements on hospitals in the treatment and transfer of patients with emergency medical conditions.

EMTALA requires hospitals to provide a medical screening examination to any individual who comes to a hospital's emergency department for treatment, without regard to ability to pay, to determine whether the individual suffers from an emergency medical condition within the meaning of EMTALA. A participating hospital may not delay providing a medical screening examination in order to inquire about method of payment or insurance status. If an emergency medical condition is present, the hospital must provide such additional medical examination and treatment as may be required to stabilize the emergency medical condition. If the hospital deems it in the best interest of the individual to transfer the individual to another medical facility, the treating physician must execute a transfer certificate complying with the standards of EMTALA and must provide a medically appropriate transfer. In addition, a hospital which receives an inappropriate transfer must report that transfer to CMS.

In regulations, CMS has extended the application of EMTALA beyond the hospital emergency department to any individual who is on hospital property and requests an examination or treatment, including individuals who are anywhere on the hospital's main campus, in a hospital owned ambulance, or in a facility determined by CMS to be an off-campus department of the hospital. Off-campus departments might include, for example, urgent care centers, primary care clinics and physical therapy and radiology facilities.

EMTALA imposes significant costs on hospitals, including the costs of treatment of individuals who may not be able to pay for those services, costs to develop and implement protocols covering medical screening examinations, stabilization and appropriate transfers and, in some cases, costs associated with assuring on-call availability of specialty physicians. In addition, the expansion of the

requirements of EMTALA to off-campus departments may result in significant costs in training personnel and the development of protocols for screening, stabilization and transportation of patients.

If a hospital violates EMTALA, whether knowingly or negligently, it is subject to a civil money penalty of up to $50,000 per violation. Failure to satisfy the requirements of EMTALA also may result in termination of the hospital's provider agreement with Medicare and/or Medicaid. In addition, EMTALA creates a private cause of action for individuals who suffer personal harm as a result of an EMTALA violation, and for any hospital that suffers financial loss as a result of another hospital's violation of EMTALA. Enforcement activity under EMTALA has increased dramatically in recent years, and because of the broad interpretation of the reach of EMTALA, there can be no assurance that Mayo Clinic or one of its affiliates will not have been found to have violated EMTALA, and if such a violation were found, that any sanctions imposed would not have a material adverse effect upon the future operations and financial condition of Mayo Clinic and its affiliates.

**Quality Reporting Requirements**. The Deficit Reduction Act ("DRA") also introduced significant new quality reporting initiatives for hospitals. Mayo Clinic and its affiliates are required to submit quality performance measures; the penalty for hospitals not reporting quality measures is a two percentage point reduction in the market basket update for that fiscal year. The ACA expands those reporting obligations.

**DRA Compliance Policy and Employee Training Requirements**. The DRA also established requirements for states participating in the Medicaid program to impose obligations on health care providers and others that receive at least $5 million annually in Medicaid payments to establish written policies and procedures designed to educate their employees (and certain contractors and agents) by providing detailed information about: (i) the federal False Claims Act and remedies under the law, (ii) administrative remedies for false claims and statements established by the Federal Program Fraud Civil Remedies Act of 1986, (iii) any state law false claims act and its remedies, (iv) the whistleblower protections provided under such laws, (v) the role of such laws in preventing and detecting fraud, waste and abuse, and (vi) the provider (or other party's) policies and procedures that are in place for the prevention and detection of fraud, waste and abuse. Providers and other covered parties that do not adequately update their compliance policies, handbooks and other training materials or otherwise abide by these requirements run the risk of losing Medicaid reimbursement and risk potential liability under the False Claims Act and other federal and state fraud and abuse laws.

**Environmental Laws Affecting Health Care Facilities**. Hospitals are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations that address, among other things, hospital operations or facilities and properties owned or operated by hospitals. In their role as owners and/or operators of properties or facilities, hospitals may be subject to liability for investigating and remedying any hazardous substances that have come to be located on the property, including any such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants, or contaminants. For these reasons, hospital operations are particularly susceptible to the practical, financial, and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property, or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; or may trigger investigations, administrative proceedings, penalties or other governmental agency actions. There can be no assurance that Mayo Clinic and its affiliates will not encounter such risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of Mayo Clinic and its affiliates.

**Transparency in Pricing**. The ACA requires hospitals to establish and make public a list of the hospital's standard charges for items and services, including MS-DRGs. A 2006 executive order was issued requiring the same public reporting of cost and quality data at four federal agencies. CMS also has made "outcomes" reporting a condition of Medicare participation. These are examples of a trend in which hospitals will be required to divulge proprietary information to the general public in order to participate in federal health care programs. The disclosure of proprietary information may have a negative impact on Mayo Clinic's ability to gain advantages in negotiations with payors. This, in turn, could negatively influence Mayo Clinic's revenues. The ACA includes various public disclosure obligations for financial arrangements between hospitals, physicians, imaging centers, and pharmaceutical and medical device manufacturers. Due to the relative novelty of these disclosure requirements, it is impossible to predict the effect, if any, that cost and outcomes reporting will have on Mayo Clinic's finances.

**Future Federal Legislation**. Mayo Clinic anticipates that the federal government's health care reform initiatives will result in further legislation, regulation, and other actions that will continue the trend toward reduced reimbursement for hospital services and more pervasive regulation of operations. For example, the National Commission on Fiscal Responsibly and Reform, a bipartisan commission appointed by President Obama, released a report in December 2010 (the "Deficit Commission Report'), which includes a number of proposals related to slowing the growth of health care costs to the federal government, including a proposal to establish a global budget for total federal health care costs and to limit, commencing in 2020, the growth of health care costs paid for by the federal government to the growth in annual gross domestic product plus 1%. At present, no determination can be made concerning whether, or in what form, such legislation could be introduced and enacted into law. Similarly, the impact of future cost control programs and future regulations on the forecasted financial performance of Mayo Clinic and its affiliates cannot be determined at this time.

Any future changes to the Medicare and Medicaid programs could result in substantial reductions in the amounts of Medicare and Medicaid payments to hospital providers in the future, which could substantially reduce the revenues available to Mayo Clinic and its affiliates, and any reduction in the levels of payment in these government payment programs could adversely affect Mayo Clinic's financial condition and its ability to fulfill its obligations.

**Regulatory Inquiries**

The laws and regulations governing federal reimbursement programs and the laws governing the health care industry generally (such as the False Claims Act, the CMP Law, the Anti-Kickback Law and the Stark Law) are complex and subject to varying interpretations, and Mayo Clinic and its affiliates are subject to contractual reviews and program audits in the normal course of business. Penalties for violations of federal regulations governing health care providers can be severe, including treble damages, fines, and suspension from federal reimbursement programs such as Medicare and Medicaid. Federal agencies have initiated nationwide investigations into several areas of concern, including, among others: (a) teaching hospitals, (b) home health care services, (c) investigational devices, (d) laboratory billing, (e) cardioverter defibrillators and (f) cost reporting. Mayo Clinic expects that the level of review and audit to which it and other health care providers are subject will increase. The ACA includes additional funding and resources to increase enforcement actions.

In contrast to a government-imposed corporate compliance plan that may be instituted pursuant to the federal government's investigation of a health care provider, a voluntary corporate compliance plan is instituted by a health care provider to put into place effective internal controls that promote adherence to various federal and state laws regulating the health care industry. The Office of Inspector General's *Compliance Program Guidance for Hospitals* was released in 1998 and supplemented in 2005. The OIG

believes that the adoption and implementation of voluntary compliance programs by hospitals significantly advances the prevention of fraud, abuse and waste in federal, state and private health plans. In fact, the OIG may consider the existence of an effective compliance plan that was instituted before a governmental investigation when negotiating a settlement with a health care provider. Mayo Clinic has compliance programs that are designed to detect and correct potential violations of laws and regulations applicable to its programs.

Regulatory authorities have discretion to assert claims for noncompliance with applicable requirements based upon their interpretation of those requirements. Because these complex program requirements are subject to varying interpretations and because, in some instances (e.g., the Anti-Kickback Law and the Stark Law), there is little clear regulatory or judicial guidance, there can be no assurance that regulatory authorities will not challenge Mayo Clinic's compliance with these requirements and assert claims or penalties, and it is not possible to determine the impact (if any) any such claims or penalties would have upon Mayo Clinic and its affiliates. Enforcement actions may pertain to not only deliberate violations, but also frequently relate to violations resulting from actions of which management is unaware, from mistakes or from circumstances where the individual participants do not know that their conduct is in violation of law. Enforcement actions may extend to conduct that occurred in the past.

Like other health care, educational and research institutions that have contracts with the federal government, Mayo Clinic and its affiliates may be subject from time to time to other regulatory inquiries, whistleblower complaints under the False Claims Act and other similar investigations. It is not possible to assess the merits of any such inquiries or investigations, complaints or inquiries at this point and, in any event, no assurances can be given as to what the impact of any such investigations, complaints or inquiries would have upon the operations or consolidated financial position of Mayo Clinic and its affiliates.

In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also heightened enforcement of laws and regulations governing the conduct of clinical trials at hospitals. HHS elevated and strengthened its Office of Human Research Protections, one of the agencies with responsibilities for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration ("FDA") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. The FDA's inspection of facilities has increased significantly in recent years. These agencies' enforcement powers range from substantial fines and penalties to exclusions of researchers and suspension or termination of entire research programs.

**Tax Exemption for Nonprofit Corporations**

Loss of exemption from federal income taxes under Section 501(c)(3) of the Code by Mayo Clinic could result in loss of tax exemption of interest on the tax-exempt bonds issued for the benefit of Mayo Clinic and its affiliates, defaults in covenants regarding other tax-exempt bonds could be triggered, and significant taxes could be owed. Such an event would have material adverse consequences on the financial condition of Mayo Clinic and its affiliates.

The maintenance by Mayo Clinic of its tax-exempt status depends, in part, upon maintaining its status as an organization described in Section 501(c)(3) of the Code. Maintaining that status is contingent upon compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and educational purposes and their avoidance of transactions that would cause their assets to inure to the benefit of private persons.

Prior to the enactment of the Taxpayer Bill of Rights 2 in 1996 (the "Intermediate Sanctions Law"), the only sanction available to the IRS for violation by a tax-exempt organization of the prohibition against private inurement was revocation of that organization's tax-exempt status. This Intermediate Sanctions Law prompted the IRS to impose a sanction less than revocation of exempt status ("intermediate sanctions") against certain tax-exempt organizations in certain circumstances. Final regulations were issued, effective in 2008, which clarified the instances where intermediate sanctions would be imposed against a tax-exempt organization instead of revocation of its exempt status.

In certain cases, the IRS has imposed substantial monetary penalties and future charity care or public benefit obligations on tax-exempt hospitals in lieu of revoking their tax-exempt status, as well as requiring that certain transactions be altered, terminated or avoided in the future and/or requiring governance or management changes. These penalties and obligations are typically imposed on the tax-exempt hospital pursuant to a "closing agreement" with respect to the hospital's alleged violation of Section 501(c)(3) exemption requirements. Given the uncertainty regarding how tax-exemption requirements may be applied by the IRS, Mayo Clinic could be at risk for incurring monetary and other liabilities imposed by the IRS in the event of a private inurement finding through this "closing agreement" or similar process. Like certain of the other business and legal risks described herein which apply to large multi-hospital systems, these liabilities are probable from time to time and could be substantial, in some cases involving millions of dollars, and in extreme cases could be materially adverse.

Intermediate sanctions may be imposed in situations in which a "disqualified person" (such as an officer, director, trustee, or key employee) (a) engages in a transaction with a tax-exempt organization on other than a fair market value basis, (b) received unreasonable compensation from a tax-exempt organization, or (c) receives payment in an arrangement that violates the prohibition against private inurement. These transactions are referred to as "excess benefit transactions."

A disqualified person who benefits from an excess benefit transaction will be subject to an excise tax equal to 25% of the amount of the excess benefit. Organizational managers who participate in the excess benefit transaction knowing it to be improper are subject to an excise tax equal to 10% of the amount of the excess benefit, subject to a maximum penalty of $20,000 per transaction. A second penalty, in the amount of 200% of the excess benefit, may be imposed on the disqualified person (but not on the organizational manager) if the excess benefit is not corrected within a specified period of time. Although it is not possible to predict what enforcement action, if any, the IRS might take related to potential excess benefit transactions, consistent with the legislative history of Section 4958, regulations issued by the IRS in March 2008 indicate that not all excess benefit transactions jeopardize exempt status. Rather, the IRS will consider all relevant facts and circumstances including: the size and scope of the organization's activities that further exempt purposes; the size, scope and frequency of any excess benefit transactions; whether the organization has implemented appropriate safeguards reasonably designed to prevent future excess benefit; and whether the organization has made good faith efforts to correct any excess benefit such as by obtaining repayment of the amount of any excess benefit.

The IRS has also taken the position that hospitals that are in violation of the Anti-Kickback Law may also be subject to revocation of their federal tax-exempt status. As a result, tax-exempt entities such as Mayo Clinic and its tax-exempt affiliates that have, and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the IRS.

The IRS has announced that it intends to closely scrutinize transactions between nonprofit organizations and for-profit entities, and in particular has issued audit guidelines for tax-exempt hospitals. Although specific activities of hospitals, such as medical office building leases and compensation arrangements, joint ventures and other contracts with independent physicians, have been the subject of

interpretations by the IRS in the form of private letter rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS.

The IRS has increased its oversight activities of tax-exempt entities, particularly health care systems and hospitals, and the IRS's enforcement efforts on issues applicable to tax-exempt organizations, such as excessive compensation, private inurement, unrelated business tax and political intervention, are expected to increase.

IRS Form 990 requires tax-exempt hospitals to report additional information about joint ventures, compensation arrangements and the charitable benefits that the hospital provides to the community. Because Mayo Clinic and its affiliates conduct large scale and diverse operations involving private parties, there can be no assurances that certain of their transactions would not be challenged by the IRS. The IRS revenue rulings provide guidance on joint ventures between taxable and tax-exempt health care entities. The revenue ruling provides generally that a nonprofit hospital must retain control over certain of the key aspects of such a joint venture (e.g., control of the governing body of the joint venture, change in types of services offered, etc.) in order to assure that the joint venture's activities are treated as primarily furthering the exempt purposes of the nonprofit, charitable organization. It is not possible at this point to determine whether the IRS guidelines for joint ventures will restrict the ability of Mayo Clinic to enter into joint ventures with taxable entities.

The tax-exempt status of nonprofit corporations, and the exclusion from taxation of income earned by them, has also been the subject of review by various federal, state and local legislative, regulatory and judicial bodies. This review has included proposals to broaden and strengthen existing federal tax law with respect to unrelated business income of tax-exempt corporations.

Bills have been introduced from time to time in Congress that would require a tax-exempt hospital to provide a certain amount of charity care and care to Medicare and Medicaid patients in order to maintain its tax-exempt status and avoid the imposition of an excise tax. The ACA imposes additional requirements for tax-exempt hospitals, including obligations to: adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amount generally charged to insured patients; and control the billing and collection processes. Additionally, tax-exempt hospitals must conduct periodic community needs assessments and adopt an implementation strategy to meet needs identified in the assessment. Final regulations interpreting various portions of these new requirements were issued on December 29, 2014, effective for taxable years beginning after December 29, 2015. Failure to satisfy these conditions may result in the imposition of an excise tax and the loss of tax-exempt status.

In addition to the new requirements described above, the ACA mandates that the U.S. Department of Treasury review information about each tax-exempt hospital's community benefit activities at least once every three years, as well as to submit an annual report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government, programs, and costs incurred by tax-exempt hospitals for community benefit activities. The periodic reviews and reports to Congress regarding the community benefits provided by 501(c)(3) hospitals may increase the likelihood that Congress will require such hospitals to provide a minimum level of charity care in order to retain tax-exempt status and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

The Subcommittee on Oversight of the United States House of Representatives Ways and Means Committee has considered options and recommendations in the area of taxation of unrelated business income of tax-exempt organizations. Hearings have been held on these options and recommendations and legislation may be drafted to clarify and strengthen existing law with respect to the unrelated business

income tax. The scope and effect of legislation, if any, that may be adopted at the federal and state levels with respect to unrelated business income cannot be predicted. Any such legislation could have the effect of subjecting a portion of a tax-exempt entity's income to federal or state income taxes.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to federal, state or local taxation of nonprofit corporations. There can be no assurance that future changes in the laws and regulations of the federal, state or local governments or audits or examinations of the activities of Mayo Clinic and its affiliates by one or more taxing authorities will not materially and adversely affect the future operations and revenues of Mayo Clinic and its affiliates by requiring them to pay income, sales or real estate taxes or to make payments in lieu of such taxes.

The IRS conducted an examination of Mayo Clinic and certain of its affiliates in 2008 through 2010 pursuant to the IRS's Exempt Organizations Team Examination Program. The examination has been closed with the exception of one issue which has been submitted for technical advice and Mayo Clinic is cooperating with IRS representatives. Although Mayo Clinic believes it has accounted for any material adverse effect on the financial condition of Mayo Clinic as a result of the examination, no such assurances can be given until the examination itself is complete. See "Professional Liability; Litigation and Regulatory Inquiries" in Appendix A.

In 2012, Mayo Clinic applied for group exemption for most of its tax-exempt subsidiaries. This was done in order to provide for more aggregate reporting as well as to streamline efforts at restructuring. Mayo Clinic's group exemption was approved in May of 2014.

The loss by Mayo Clinic and/or its tax-exempt affiliates of federal tax exemption could also result in a challenge to the state tax exemption of these organizations. A loss of state tax-exempt status could impose additional costs, possibly material, on the affected affiliates and could result in the loss of real estate and other state tax exemptions for Mayo Clinic and its tax-exempt affiliates.

In addition to the issues related to tax exemption for the entity, the IRS has issued "compliance checks" relating to post-issuance compliance of tax-exempt bonds issued for exempt organizations and has increased disclosure on Form 990 related to post-issuance compliance policies. Although Mayo Clinic entities have not received any such inquiries, the information obtained from these inquiries may lead to additional legislative or regulatory changes which could have an effect on the tax-exempt status of the interest on the bonds issued for the benefit of Mayo Clinic or other negative consequences.

**State Tax Exemptions for Nonprofit Corporations**

**State and Local Income Tax Exemption**. Until recently, states have not been as active as the IRS in scrutinizing the income tax exemption of health care organizations. Legislation that would result in further regulation and supervision of nonprofit corporations generally is introduced from time to time in state legislatures. The loss by Mayo Clinic or one of its tax-exempt affiliates of federal tax exemption could very well trigger a challenge to its state or local tax exemption. Depending on the circumstances, such a challenge, if successful, could be material and adverse.

**Real Property Tax Exemptions**. The real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities have been challenged on the theory that the health care providers were not sufficiently engaged in charitable activities. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins. While Mayo Clinic is not aware of any current challenge to the tax exemption afforded to any material real property of any of its nonprofit affiliates, there can be no assurance that these types of challenges will not occur in the future.

**Other State and Local Taxes**. Mayo Clinic and its affiliates have operations in many different states. The types of taxes vary from state to state including sales and use taxes, excise taxes, franchise taxes, personal or tangible property taxes, and many others. The extent of available exemptions from these taxes also varies from state to state. There can be no assurance that a challenge to exemption from one of these taxes, or a change in legislation or regulation, will not materially adversely affect the consolidated financial condition of Mayo Clinic and its affiliates

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of nonprofit corporations. There can be no assurance that future changes in the laws and regulations of state or local governments will not materially adversely affect the consolidated financial condition of Mayo Clinic and its affiliates by requiring payment of income, local property or other taxes.

**Other Legislative and Regulatory Actions**

Mayo Clinic and its affiliates are subject to regulation, certification and accreditation by various federal, state and local government agencies and by certain nongovernmental agencies such as the Joint Commission and the American Medical Association. Mayo Clinic is also subject to regulatory actions and policy changes by the various federal, State and local agencies created by the National Health Planning and Resources Development Act, the Occupational Safety Health Act, the act creating the Environmental Protection Agency and other federal, State and local governmental agencies. No assurance can be given as to the effect on future hospital operations of existing laws, regulations and standards for certification or accreditation or of any future changes in such laws, regulations and standards.

Legislative proposals which could have an adverse effect on Mayo Clinic and its affiliates include: (a) any change in the taxation of not for profit corporations or in the scope of their exemption from income or property taxes; (b) limitations on the amount or availability of tax-exempt financing for charitable organizations described in Section 501(c)(3) of the Code; (c) possible non-access to tax-exempt debt by hospitals described in Section 501(c)(3) of the Code; (d) regulatory limitations affecting the ability of Mayo Clinic and its affiliates to undertake capital projects or develop new services; (e) limitations on the deductibility of charitable contributions for federal income tax purposes; and (f) a requirement that nonprofit health care institutions pay real estate property tax and sales tax on the same basis as for-profit entities. Mayo Clinic currently pays real estate taxes on those of its clinic facilities (or portions of facilities) in Rochester, Minnesota which are not used for its educational or research activities.

Additionally, over the past several years, various proposals to make significant automatic decreases in federal spending, including in the Social Security program and Medicare program, as well as changes in taxes, have been enacted. One proposed change in tax law would limit the deductibility of interest on tax exempt bonds for higher income persons, which could increase borrowing costs for nonprofit organizations like Mayo Clinic. The proposals, often referred to as "fiscal cliff" proposals, require Congress and the Executive Branch to take actions by specified dates or else automatic spending cuts or tax increases and other tax benefits limitations will take effect. In the past two years, Congress has acted to forestall certain of these tax increases and spending cuts by approving interim measures. It is not possible to predict the impact that the failure to take such actions or to extend fiscal cliff deadlines could have on health care, research, education or the economy generally.

**Antitrust**

Mayo Clinic and its affiliates, like other providers of health care services, are subject to antitrust laws. Those laws generally prohibit agreements that restrain trade and prohibit the acquisition or

maintenance of a monopoly through anticompetitive practices. The legality of particular conduct under the antitrust laws generally depends on the specific facts and circumstances and, in some circumstances, cannot be predicted in advance. Antitrust actions against health care providers have become increasingly common in recent years. Antitrust liability can arise in a number of different contexts, including medical staff privilege disputes, third-party payor contracting, joint ventures and affiliations between health care providers, and mergers and acquisitions by health care providers. Actions can be brought by federal and state enforcement agencies seeking criminal and civil penalties and, in some instances, by private plaintiffs seeking damages for harm from allegedly anticompetitive behavior.

Recent judicial decisions have permitted physicians who are subject to disciplinary or other adverse actions by a hospital at which they practice, including denial or revocation of medical staff privileges, to seek treble damages from the hospital under the federal antitrust laws. The Federal Health Care Quality Improvement Act of 1986 provides immunity from liability for discipline of physicians by hospitals under certain circumstances, but courts have differed over the nature and scope of this immunity. In addition, hospitals occasionally indemnify medical staff members who incur costs as defendants in lawsuits involving medical staff privilege decisions. Recent court decisions have also permitted recovery by competitors claiming harm from a hospital's use of its market power to obtain unfair competitive advantage in expanding into ancillary health care businesses. Antitrust liability in any of these contexts can be substantial, depending upon the facts and circumstances involved.

The United States Department of Justice and the Federal Trade Commission issued "Statements of Antitrust Enforcement Policy in the Health Care Area." The statements, which have been revised from time to time, generally describe certain analytical principles which the agencies will apply to certain factual situations and also establish certain "antitrust safety zones." Conduct within the safety zones will not be challenged by the agencies, absent extraordinary circumstances. Many activities frequently engaged in by health care providers fall outside of the zones but are not challenged, and failure to fall within a safety zone does not mean that a participant will be investigated or prosecuted, or even that the activity violated the antitrust laws. There cannot be any assurances that enforcement authorities or private parties will not assert that Mayo Clinic or its affiliates, or any transaction in which they are involved, are in violation of the antitrust laws.

**Licensing, Surveys and Accreditations**

Health care facilities, including those of Mayo Clinic and its affiliates, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. Those requirements include credentialing and survey requirements relating to Medicare and Medicaid participation and payment, state licensing agencies, private payor participation, the Joint Commission, the National Labor Relations Board and other federal, state and local government agencies. Renewal and continuance of certain of these licenses, certifications and accreditations are based on inspections, surveys, audits, investigations or other reviews. These activities are generally conducted in the normal course of business of health care facilities. Nevertheless, an adverse result could be the cause of loss or reduction in a facility's scope of licensure, certification or accreditation or reduce payments received.

Management of Mayo Clinic currently anticipates no difficulty in renewing or maintaining currently held licenses, certifications or accreditations that are material to its operations, and does not anticipate a reduction in third-party payments that would materially adversely affect the financial condition, operations, revenues and expenses of Mayo Clinic due to licensing, certification or accreditation difficulties. Nevertheless, there can be no assurance that the requirements of present or future laws, regulations, certifications, and licenses will not materially and adversely affect the operations of Mayo Clinic. Actions in any of these areas could occur and could result in a reduction in utilization or revenues or both, or the loss of Mayo Clinic's ability to operate all or a portion of its health care facilities,

and, consequently, could adversely affect Mayo Clinic's financial condition, operations, revenues and expenses or its ability to make payments of principal, interest or any premium coming due on the Bonds.

**Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures**

Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers such as Mayo Clinic and its affiliates. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition.

**Pharmaceutical and Technological Changes**

Medical research and resulting discoveries have grown exponentially in the last decade. These new discoveries may add greatly to costs of providing health care services with no or little offsetting increase in federal reimbursement and may also render obsolete certain of the health services provided by health care providers. New drugs and devices may increase hospitals' expenses because, for the most part, the costs of new drugs and devices are not typically accounted for in the DRG payment received by hospitals for inpatient care and are often not covered for outpatient services. Similarly, increased utilization of expensive pharmaceutical products or therapies would increase health plan expenses, all of which could negatively affect Mayo Clinic.

**Medical Professional Liability Insurance Market**

Deteriorating underwriting results have generated substantial premium increases and coverage reductions in the medical professional liability insurance marketplace in recent years. A rise in claim severity nationwide, coupled with the lower investment returns available to insurers, have resulted in substantial reductions in medical professional liability insurance capacity. Several major medical professional liability insurance carriers have been forced into rehabilitation and/or liquidation, or have voluntarily withdrawn from this line of business. The insurance carriers who are still writing medical professional liability coverage are requiring substantial premium increases, reductions in the breadth of coverage afforded by the policy(ies), more stringently enforced policy terms, and increases in required deductibles or self-insured retentions. Health care entities that have self-funded programs are also experiencing similar difficulties with respect to fronting carriers, reinsurance on their captive insurance companies and/or with respect to insurance placements excess of the primary coverage layers. Furthermore, insurance carrier insolvencies are forcing health care providers to either repurchase insurance coverage from new carriers at substantially higher rates, or self insure exposures for which they had previously purchased insurance.

Mayo Clinic maintains a formal program of self-insurance for the financial risk of professional liability at Mayo's clinical and hospital sites. Some of Mayo Clinic's affiliates obtain professional liability coverage through Mayo Insurance Company Limited, a wholly owned subsidiary of Mayo Clinic. Medical liability and managed care litigation are subject to public policy determinations and legal and procedural rules that may be altered from time to time, with the result that the frequency and cost of such litigation and resultant liabilities may increase in the future. There can be no assurance that the

unpredictability and increasing severity of jury awards and claims payouts will not adversely affect the operations or financial condition of Mayo Clinic and its affiliates. See Appendix A.

**Nationwide Nursing Shortage**

The health care industry is facing a nationwide shortage of nursing professionals, including registered nurses. A shortage of nursing staff could result in escalating labor costs, delays in providing care, and patient care management issues, among other adverse effects. The shortage of nurses and other primary care healthcare practitioners may be exacerbated if the increase in access to coverage provided under the ACA leads to an increase in demand for medical care. The ACA includes numerous workforce programs that should have an impact on existing and projected nursing shortages and increase the availability of other primary care health practitioners. There can be no assurance that a nursing or other non-physician health care practitioner shortage will not adversely affect the operations or financial condition of Mayo Clinic. Although legislation has been introduced at both the state and federal level to mitigate the impact of the existing and projected nursing shortages, there can be no assurance that a nursing shortage will not adversely affect the operations or financial condition of Mayo Clinic and its affiliates.

**Physician Supply**

Sufficient community-based physician supply is important to hospitals and health systems. A shortage of physicians, especially in primary care, could become a significant issue for health providers to face in the coming years. Any physician shortage will be compounded by the expansion of coverage to the uninsured under the ACA. In addition, CMS annually reviews overall physician reimbursement formulas. Changes to physician compensation formulas could lead to physicians locating their practices in communities with lower Medicare and Medicaid populations. Mayo Clinic may be required to invest additional resources for recruiting and retaining physicians or may be required to increase the percentage of employed physicians in order to continue serving the growing population base and maintain market share.

**Physician Contracting**

At certain locations, Mayo Clinic may contract with physician organizations (such as independent physician associations, physician-hospital organizations, and accountable care organizations) to arrange for the provision of physician and ancillary services. Because physician organizations are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with physician organizations.

The success of Mayo Clinic is partially dependent upon its ability to attract physicians to join the physician organizations at facilities it operates and upon the ability of the physicians, including the employed physicians, to perform their obligations and deliver high quality patient care in a cost-effective manner. There can be no assurance that Mayo Clinic will be able to attract and retain the requisite number of physicians, or that physicians will deliver high quality health care services. Without contracting with a sufficient number and type of providers, Mayo Clinic could fail to be competitive, could fail to keep or attract payer contracts, or could be prohibited from operating until its physician organizations provide adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of Mayo Clinic.

**Health Care Worker Classification**

Health care payers and providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. If the IRS were to reclassify a significant number of independent contractors of Mayo Clinic (e.g., physician medical directors at hospitals) as employees, back taxes and penalties could be material.

**Competition**

Mayo Clinic and its affiliates face, and will continue to face, competition from other hospitals and physicians that offer comparable health care services. Competition exists from alternative modes of health care delivery that offer lower priced services to the same population. Such alternative modes include ambulatory surgery centers, private laboratories and radiology services, skilled and specialized nursing facilities and home health care. Physicians increasingly offer outpatient ancillary services that compete with certain services offered by hospitals. Further, Mayo Clinic and its affiliates compete for patient volume with an increasing number of for-profit hospitals. No assurance can be given that increasing competition and consolidation of providers in the service areas will not have a materially adverse effect on the financial condition and operations of Mayo Clinic and its affiliates.

**Labor Relations and Collective Bargaining**

Hospitals are large employers with a wide variety of employees. Overall costs of the workforce are high and turnover can also be high. Pressure to recruit, train and retain qualified employees is expected to accelerate. These factors may materially increase costs of operation.

Increasingly, employees of hospitals are becoming unionized and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel as well as food services, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to hospitals. Employee strikes or other unfavorable labor actions may have an adverse impact on operations, revenue and hospital reputation.

Additionally, Federal law and many states impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces are susceptible to actual and alleged violations of these standards In recent years, there has been a proliferation of lawsuits over these “wage and hour” issues, often in the form of large, sometimes multi-state, class actions. For large employers such as hospitals and health systems, such class actions can involve multi-million dollar claims, judgments and/or settlements. A major class action decided or settled adversely to Mayo Clinic could have a material adverse impact on its financial condition and result of operations.

**Construction Risks**

From time to time, Mayo Clinic and its affiliates undertake significant construction projects. There are certain risks inherent in any major construction project that could affect the timing and completion and the overall cost of such projects, including delays in the issuance of required building and occupancy permits, strikes, shortages of materials and adverse weather conditions. Such events could result in delaying occupancy of such projects and thus the revenue flow therefrom.

**Considerations Relating to Additional Debt**

The Indenture permits Mayo Clinic or its subsidiaries to incur additional indebtedness or to guarantee debt without satisfying any financial tests. Any such indebtedness would increase Mayo Clinic's debt service and repayment requirements and may adversely affect debt service coverage on the Bonds. See "OUTSTANDING INDEBTEDNESS" and "SECURITY FOR THE BONDS."

**General Commercial and Economic Factors**

**General**. The domestic and international economic downturn of the past several years has had, and may continue to have, negative impacts upon the national and global economies, including a tightening of credit, decreased confidence in the financial sector, volatility in the financial markets, increase in interest rates, reduced business activity, increased business failures and increased consumer and business bankruptcies. The ongoing repercussions of the economic downturn may adversely affect Mayo Clinic's expenses and, consequently, its ability pay debt service on its debt.

The current conditions in credit markets may cause Mayo Clinic's ability to borrow to fund capital expenditures to be more limited and more expensive. The credit market situation has also caused a number of financial institutions to restrict lending, including extending the term of liquidity and credit facilities. No assurance can be given that any of the financial institutions currently providing liquidity facilities or credit facilities for Mayo Clinic debt will renew or extend those facilities or that Mayo Clinic will be able to obtain alternate liquidity for certain of its variable rate bonds on comparable terms.

**Market Value of Investments**. Earnings on investments have historically provided Mayo Clinic an important source of cash flow and capital appreciation to support its programs and services, to finance its capital expenditure investments and to build its cash reserves. As of December 31, 2015, the market value of Mayo Clinic's investments, which include cash, short term securities, fixed income securities, common stock, preferred stock, mutual funds and other investment assets totaled $7,225 million. See "Management's Discussion – Investment Program" in Appendix A for a description of Mayo Clinic's investment program. Historically, the value of both debt and equity securities has fluctuated and, during some periods, the fluctuations have been quite significant. The market disruption has exacerbated the market fluctuations and has affected the investment performance of securities in Mayo Clinic's portfolio. In 2015, Mayo Clinic experienced an investment gain of $122 million on its $7,225 million in investment assets. No assurances can be given that the market value of Mayo Clinic's investments will continue to grow, or even remain at its current level and there is risk that it may actually decline.

**Pension Funding Impact**. Changes in market interest rates and debt and equity market fluctuations also potentially could have an impact on Mayo Clinic's pension fund liabilities and its requirements for funding its related pension expenses (See "Management's Discussion – Pension Fund" in Appendix A). Like any other entity with pension fund liabilities, Mayo Clinic finds that increases or decreases in interest rates have an impact on the assumed earnings rates on pension assets needed to match pension fund liabilities, which accordingly affects the levels of actuarial pension investment assets required to meet future pension obligations. Consequently, any substantial and sustained decline in long-term interest rates, as is currently the case, could have the effect of increasing Mayo Clinic's current pension funding requirements. In addition, the Pension Protection Act of 2006 (the "PPA") has accelerated the minimum funding requirements for many defined benefit pension plans. This change, together with new rules for measuring pension plan assets and liabilities, including new actuarial assumptions and asset valuation rules included in the PPA, has generally increased employers' required minimum funding contributions to pension plans. No assurance can be given that Mayo Clinic will not be required to make increased pension funding payments in these or other circumstances.

**Banking Industry Risk**. Declines and disruptions in the financial markets over the past four years have affected and continue to affect the municipal bond market and the commercial banks, including the liquidity enhancers of certain of Mayo Clinic's currently outstanding variable rate bonds (the "Mayo Liquidity Providers"). These developments have had a serious adverse effect on the financial condition of a number of financial institutions, weakening their credit status as reflected in their credit ratings. Future deterioration of the financial condition of the Mayo Liquidity Providers may lead to rating downgrades or adverse rating actions for certain of Mayo Clinic's outstanding bonds and may result in higher interest rates paid by Mayo Clinic on such bonds and, therefore, have an adverse financial impact on Mayo Clinic.

**Contributions**. Volatile financial markets and slowing economic growth or recession can have an adverse impact on Mayo Clinic's total receipts of charitable contributions, which have historically served as a material source of support for Mayo Clinic's programs and services. Over the last three years, Mayo Clinic's total receipts from charitable contributions, net of changes in pledges, gains/losses on internal and externally managed trusts and expenses, totaled $931.7 million or an average of $310.6 million annually. Mayo Clinic received contributions, net of changes in pledges, gains/losses on internal and externally managed trusts and expenses, totaling approximately $276.6 million in 2014, and approximately $271.0 million in 2015. No assurances can be given that Mayo Clinic will continue to receive charitable contributions at historical levels.

**Cybersecurity.** Like many other large organizations, Mayo Clinic relies on electronic systems and technologies to conduct its operations in support of its medical treatment activities, its finances and its research and educational activities.

In the past several years, a number of entities have sought to gain unauthorized access to electronic systems of large organizations for the purposes of misappropriating assets or personal, operational, financial or other sensitive information, or causing operational disruption. These attempts, which are increasing, include highly sophisticated efforts to electronically circumvent security measures as well as more traditional intelligence gathering aimed at obtaining information necessary to gain access.

Mayo Clinic maintains a security posture designed to deter "cyber attacks", has established an Office of Information Security, and is committed to deterring attacks on its electronic systems and responding to such attacks to minimize their impact on operations. However, no assurances can be given that Mayo Clinic's security measures will be able to prevent cyber attacks on its electronic systems, and no assurances can be given that any cyber attacks, if successful, will not have a material adverse effect on the operations or financial condition of Mayo Clinic and its affiliates.

**Potential Effects of Bankruptcy**

If Mayo Clinic were to file a petition for relief under the federal Bankruptcy Code, the filing would act as an automatic stay against the commencement or continuation of judicial or other proceedings against the petitioner and its property.

Any petitioner for relief may file a plan for the adjustment of its debts in a proceeding under the federal Bankruptcy Code which could include provisions modifying or altering the rights of creditors generally, or any class of them, secured or unsecured. The plan, when confirmed by the court, would bind all creditors who had notice or knowledge of the plan and discharge all claims against the petitioner provided for in the plan. No plan may be confirmed unless certain conditions are met, including that the plan is in the best interests of creditors, is feasible and has been accepted by each class of claims impaired thereunder. Each class of claims will be deemed to have accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the allowed claims of the class that are voted with respect to

the plan are cast in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly.

**Enforceability of Certain Covenants**

The Indenture obligates Mayo Clinic to exercise all control it may have over its subsidiaries to cause them to pay, loan or otherwise transfer to Mayo Clinic amounts necessary to pay debt service on the Bonds as the same becomes due and payable. This agreement by Mayo Clinic may not be enforceable to the extent such funds (a) are requested to make payments on any bonds issued for a purpose not consistent with the charitable purposes of the affiliate from which such payment is required or which are issued for the benefit of any entity other than a tax-exempt organization; (b) are requested to be made from any property which is donor restricted or which is subject to a direct or express trust which does not permit the use of such property of such payments; or (c) would result in the cessation or discontinuation of any material portion of the health-care or related services previously provided by the affiliate from which such payment is required. Due to the absence of clear legal precedent in this area, the extent to which the property of any affiliates of Mayo Clinic currently falls within the categories referred to above cannot be determined and could be substantial.

There is no clear precedent in the law as to whether transfers from an affiliate in order to pay debt service on bonds issued for the benefit of another affiliate may be voided by a trustee in bankruptcy in the event of a bankruptcy of the transferring affiliate or pursuant to state fraudulent conveyances statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under certain state fraudulent conveyances statutes, a creditor of a related guarantor may avoid any obligation incurred by a related guarantor, if, among other factors, (a) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty, and (b) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or certain state fraudulent conveyances statutes, or the guarantor is undercapitalized.

Application by courts of the tests of "insolvency," "reasonably equivalent value" and "fair consideration" has resulted in a conflicting body of case law. It is possible that, in an action to force one Mayo affiliate to pay debt service on bonds issued for the benefit of another Mayo affiliate, a court might not enforce such a payment in the event it is determined that the affiliate is analogous to a guarantor, that fair consideration or reasonably equivalent value of such guarantee was not received and that the incurrence of such obligation has rendered and will render the transferring affiliate insolvent or the transferring affiliate is or will thereby become undercapitalized.

There exists common law authority and authority under state statutes for the ability of the courts to terminate the existence of a nonprofit corporation or undertake supervision of its affairs on various grounds, including a finding that the corporation has insufficient assets to carry out its stated charitable purposes. Such a court action may arise on the court's own motion or pursuant to a petition of a state attorney general or such other persons who have interests different from those of the general public, pursuant to common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

**Other Factors**

The following, among others, may adversely affect future operations of health care, educational and research institutions, including Mayo Clinic and its affiliates, to an extent that cannot be determined at this time:

- Changes to the Medicare program, and the impacts on economic conditions generally of higher taxes and decreases in federal spending arising out of legislation to respond to "fiscal cliff" or budget "sequestration" concerns and actions.

- Imposition of wage or price controls on the health care industry by state or federal government.

- Adoption of a national healthcare program.

- Repeal or modification of federal health care reform legislation.

- Potential depletion of the Medicare trust fund.

- Continued availability of governmental and private funding for medical research activities conducted by Mayo Clinic or its affiliates.

- Increased medical malpractice claims (affecting Mayo Clinic and its affiliates or in general) which affect the cost and availability of professional liability insurance, and sufficiency of self-insurance reserves.

- Employee strikes and other adverse labor actions that could result in a substantial reduction in revenues without corresponding decreases in costs.

- Reduced need for hospitalization or other medical services arising from future medical and scientific advances.

- Increased unemployment or other adverse economic conditions which would increase the proportion of patients who are unable to pay fully for the cost of their care.

- Increased competition from other hospitals and other health care providers that offer health care services to the populations which Mayo Clinic and its affiliates serve.

- Efforts by insurers and governmental agencies to limit the cost of hospital services and to reduce the utilization of health care facilities by such means as preventive medicine, improved occupational health and safety and outpatient care.

- Acts of terrorism or outbreaks of war affecting the United States.

- Any inability to obtain any required governmental approvals for necessary capital expenditures.

- Health care delivery operations are capital intensive. Regulation technology and physician/patient expectations require constant and often significant capital investment. Total capital needs may be greater than the availability of funds to provide capital investment.

- The occurrence of natural disasters, including floods, tornados and hurricanes, which might damage the facilities of Mayo Clinic and/or its affiliates.

- Adverse conditions in United States and global investment and capital markets.

## CONTINUING DISCLOSURE

Mayo Clinic has entered into continuing disclosure undertakings (the "Continuing Disclosure Undertakings") in connection with the sales of tax-exempt revenue bonds issued for the benefit of Mayo Clinic and its affiliates. Holders and prospective purchasers of the Bonds may obtain copies of the information provided by Mayo Clinic under those Continuing Disclosure Undertakings on the Municipal Securities Rulemaking Board's Electronic Municipal Market Access system ("EMMA"). Each Continuing Disclosure Undertaking terminates when the related tax-exempt revenue bonds are paid or deemed paid in full.

Mayo Clinic from time to time is required to render reports concerning compliance with the Indenture as the Trustee may reasonably request. Within 120 days after the close of each of its fiscal years, Mayo Clinic is required to furnish to the Trustee and make available to the public on EMMA copies of its audited financial statements. Within 60 days after the close of each of its fiscal quarters, Mayo Clinic is required to furnish to the Trustee or make available on to the public on its website copies of its unaudited financial statements for such quarter. Mayo Clinic is required to furnish to the Trustee, within 60 days after the close of each fiscal year, a certificate signed by an Authorized Representative stating that Mayo Clinic has caused its operations for the year to be reviewed and that in the course of that review, no default under the Indenture has come to its attention or, if such a default has appeared, a description of the default. The Indenture provides that sole remedy for the violation of this covenant is to compel specific performance.

## CERTAIN UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS

The following discussion summarizes certain United States federal income tax considerations generally applicable to the purchase, ownership, and disposition of the Bonds. The discussion is limited to the tax consequences to the initial purchasers of the Bonds that purchase the Bonds at their issue price (i.e., the first price at which a substantial amount of Bonds is sold to persons other than bond houses, brokers, or similar persons or organizations acting in the capacity of underwriters, placement agents, or wholesalers) and that will hold the Bonds as capital assets within the meaning of Section 1221 of the Code. This summary is based on the Code, final, temporary and proposed U.S. Treasury regulations, and administrative and judicial interpretations, all of which are subject to change, possibly with retroactive effect.

The discussion below does not purport to be a complete analysis of all of the potential United States federal income tax consequences relating to the purchase, ownership, and disposition of the Bonds. The discussion does not address all aspects of taxation that might be relevant to particular purchasers in light of their individual circumstances or special rules applicable to certain categories of purchasers, such as dealers in securities or foreign currencies, insurance companies, regulated investment companies, real estate investment trusts, real estate mortgage investment conduits, financial institutions, tax-exempt entities, former citizens or residents of the United States, partnerships or other pass-through entities, investors that hold the Bonds as part of a hedge, straddle, conversion, constructive sale or other integrated transaction, and investors that have a functional currency that is not the United States dollar, all of which categories of investors may be subject to tax rules that differ significantly from those summarized below. The discussion does not address U.S. federal estate, gift, or alternative minimum tax considerations, non-U.S. tax considerations, or state or local tax considerations.

For the purposes of this summary, a "U.S. Holder" is a beneficial owner of a Bond that is, for United States federal income tax purposes: (1) an individual who is a citizen or resident of the United States, (2) a corporation, partnership or other entity created or organized in or under the laws of the

United States or of any political subdivision thereof, (3) an estate, the income of which is subject to United States federal income taxation regardless of its source, or (4) a trust, the administration of which is subject to the primary supervision of a court within the United States and which has one or more United States persons with authority to control all substantial decisions of the trust, or a trust in existence on and after August 20, 1996 that has made a valid election under U.S. Treasury regulations to be treated as a domestic trust. A "Non-U.S. Holder" is a beneficial owner of Bonds that is not a U.S. Holder.

Prospective investors should consult their own tax advisors as to the tax consequences to them from the purchase, ownership, and disposition of the Bonds in light of their particular circumstances.

**U.S. Holders**

**Interest**. Interest on the Bonds generally will be taxable to a U.S. Holder as ordinary income at the time the interest accrues or is received in accordance with the U.S. Holder's method of accounting for United States federal income tax purposes.

**Original Issue Discount**. The Bonds will be treated as issued with original issue discount ("OID") if their principal amount exceeds their issue price by at least a *de minimis* amount (0.25% of the principal amount multiplied by the number of complete years from the issue date of the Bonds until their maturity). If the Bonds are treated as issued with OID, a U.S. Holder generally will be required to include OID in income as it accrues based on a constant-yield-to-maturity method before the receipt of corresponding cash payments. Under this method, U.S. Holders generally will be required to include in income increasingly greater amounts of OID in successive accrual periods.

The remainder of this discussion assumes that the Bonds are issued with less than a *de minimis* amount of OID.

**Bond Premium**. A U.S. Holder that purchases a Bond for an amount greater than the sum of all amounts payable on the Bond after the acquisition date (other than payments made at least annually over the term of the Bond as stated interest) will have amortizable bond premium. If the U.S. Holder elects to amortize the bond premium, such election will apply to all Bonds held by the U.S. Holder on the first day of the taxable year to which the election applies, and to all taxable bonds thereafter acquired by the U.S. Holder and is irrevocable without the consent of the Internal Revenue Service (the "IRS"). The premium must be amortized using constant yield principles based on the U.S. Holder's yield to maturity (or, in some cases, to earlier call date). Amortizable bond premium is generally treated as an offset to interest income, but a reduction in basis is required for amortizable bond premium even though the premium has been applied to reduce interest payments. Bond premium on a Bond held by a U.S. Holder that has not elected to amortize bond premium will decrease the gain or increase the loss otherwise recognized on the disposition of the Bond.

**Sale or other Disposition of the Bonds**. In general, upon the sale, exchange, redemption, retirement, or other taxable disposition of a Bond, a U.S. Holder will recognize capital gain or loss equal to the difference between the amount realized on such disposition (not including any amount attributable to accrued but unpaid interest that the U.S. Holder has not already included in gross income) and such U.S. Holder's adjusted tax basis in the Bond. Any amount attributable to accrued but unpaid interest that the U.S. Holder has not already included in gross income will be treated as a payment of interest. A U.S. Holder's adjusted tax basis in a Bond generally will equal the cost of the Bond to the U.S. Holder, (i) reduced by any principal payments received by the U.S. Holder and the amount of any amortizable bond premium applied to reduce interest on the Bond and (ii) increased by any accrued but unpaid interest and original issue discount that the U.S. Holder has included in taxable income.

**Tax-Exempt Organizations**. Income or gain realized from Bonds held by a tax-exempt organization will be subject to the tax on unrelated business taxable income if the Bonds are "debt-financed property" of the organization under Section 514(b) of the Code.

**Unearned Income Tax**. A U.S. Holder that is an individual or estate, or a trust that does not fall into a special class of trusts that is exempt from such tax, will be subject to a 3.8% tax on the lesser of (1) the U.S. Holder's "net investment income" for the relevant taxable year and (2) the excess of the U.S. Holder's adjusted gross income (increased by certain amounts of excluded foreign income) for the taxable year over a certain threshold (which in the case of individuals will be between $125,000 and $250,000, depending on the individual's circumstances) (the "Unearned Income Tax"). A U.S. Holder's net investment income will generally include its interest income and net gain from the disposition of the Bonds, unless such interest income and net gain is derived in the ordinary course of the conduct of a trade or business (other than a trade or business that consists of certain passive or trading activities). Net investment income may, however, be reduced by properly allocable deductions to such income. U.S. Holders that are individuals, estates or trusts are urged to consult their tax advisors regarding the applicability of the Unearned Income Tax to their income and gains from the Bonds.

**Non-U.S. Holders**

Payments of interest on a Bond to a Non-U.S. Holder generally will be treated as "portfolio interest" and will not be subject to United States federal income tax or nonresident withholding tax, provided that:

- the Non-U.S. Holder (i) does not actually or constructively own 10% or more of the total combined voting power of all classes of stock of the issuer entitled to vote; (ii) is not a controlled foreign corporation with respect to which the issuer is a "related person" within the meaning of Section 864(d)(4) of the Code; and (iii) is not a bank receiving interest described in Section 881(c)(3)(A) of the Code;

- either (i) the Non-U.S. Holder provides its name and address, and certifies, under penalties of perjury on IRS Form W-8BEN, W-8BEN-E, W-8IMY or W-8EXP, as applicable, to the issuer, its paying agent or other applicable withholding agent, as the case may be, that such holder is a Non-U.S. Holder or (ii) a securities clearing organization, bank or other financial institution that holds customers' securities in the ordinary course of its trade or business ("financial institution") and holds a Bond on behalf of the Non-U.S. Holder certifies, under penalties of perjury, to the issuer or its paying agent that such certificate has been received from the Non-U.S. Holder by it or by any intermediary financial institution and furnishes the issuer or its paying agent with a copy of the certificate; and

- the interest is not effectively connected with the conduct of a trade or business within the United States under Section 871(b) or Section 882 of the Code.

A Non-U.S. Holder that does not satisfy any of the foregoing exemption requirements is generally subject to United States withholding tax on payments of interest or accrual of original issue discount.

Interest on a Bond that is effectively connected with the conduct of a United States trade or business by the Non-U.S. Holder is generally subject to United States federal income tax in the same manner as with a U.S. Holder, except to the extent otherwise provided under an applicable tax treaty. Effectively connected interest income received by a corporate Non-U.S. Holder may also, under certain circumstances, be subject to an additional branch profits tax. Effectively connected interest income will

not be subject to withholding tax if the Non-U.S. Holder delivers a properly completed IRS Form W-8ECI to the issuer or its paying agent.

**Sale or other Disposition of the Bonds**. In general, a Non-U.S. Holder of a Bond will not be subject to United States federal income or withholding tax on the receipt of payments of principal on a Bond and will not be subject to United States federal income tax on any gain recognized on the sale, exchange, redemption, retirement or other taxable disposition of a Bond unless:

- the Non-U.S. Holder is a nonresident alien individual who is present in the United States for 183 or more days in the taxable year of disposition and certain other conditions are met under Section 871(a)(2) of the Code; or

- the gain is effectively connected with the conduct of a trade or business within the United States under Section 871(b) or Section 882 of the Code (or pursuant to an applicable tax treaty is attributable to a United States permanent establishment of the Non-U.S. Holder).

**Information Reporting and Backup Withholding**

In general, payments on the Bonds and on the proceeds of a sale or other disposition of the Bonds will be reported to the IRS and to the holder as may be required under applicable regulations.

Backup withholding will apply to payments to a U.S. Holder if the U.S. Holder fails to provide an accurate taxpayer identification number or certification of exempt status or otherwise to comply with the applicable backup withholding requirements. Certain U.S. Holders are not subject to backup withholding. Payments on the Bonds and on the proceeds of a sale or other disposition of the Bonds payable to a Non-U.S. Holder generally will not be subject to backup withholding and information reporting requirements if certification on the appropriate IRS Form W-8 is provided by the Non-U.S. Holder to the payor and the payor does not have actual knowledge that the certification is false.

**FATCA**

Under the Foreign Account Tax Compliance Act ("FATCA") contained in Sections 1471 through 1474 of the Code, foreign financial institutions (which generally include hedge funds, private equity funds, mutual funds, securitization vehicles and other investment vehicles regardless of their size) that are not otherwise exempt from FATCA must comply with information reporting rules with respect to their U.S. account holders and investors or, regardless of the treatment of payments on the Bonds under the general income tax rules applicable to Non-U.S. Holders that are discussed above, confront a separate withholding tax. Specifically, FATCA requires that each foreign financial institution enter into an agreement with the United States government to collect and provide the IRS substantial information regarding U.S. account holders of such foreign financial institution, comply with the terms of an applicable intergovernmental agreement between the United States and such foreign financial institution's jurisdiction of formation (an "IGA"), or establish an exemption from FATCA. Additionally, FATCA requires certain foreign entities that are not financial institutions to provide the withholding agent with a certification identifying the substantial U.S. owners of such foreign entity, if any.

A foreign financial institution or other foreign entity that does not comply with the FATCA reporting requirements is subject to a 30% withholding tax with respect to any "withholdable payments." For this purpose, "withholdable payments" include U.S. source payments of taxable interest and the entire gross proceeds from the sale of any debt instruments of U.S. issuers. FATCA withholding on gross proceeds generally will apply to payments of gross proceeds made after December 31, 2018. The FATCA withholding tax applies regardless of whether the payment would otherwise be exempt from U.S.

nonresident withholding tax (e.g., under an income tax treaty, the portfolio interest exemption or as capital gain). FATCA withholding does not apply to withholdable payments made directly to foreign governments, international organizations, foreign central banks of issue and individuals, and the Treasury is authorized to provide additional exceptions.

The United States has entered into, and continues to negotiate IGAs with a number of other jurisdictions to facilitate the implementation of FATCA. The IRS has released periodic guiadance regarding which IGAs will be treated as being in force. Most recently, the IRS announced in Notice 2015-66, I.R.B. 2015-41 (September 18, 2015) that foreign financial institutions resident in certain jurisdictions that have signed IGAs or reached agreements in substance on the text of an IGA, but have not brought the IGA into force, will be treated as complying with FATCA's provisions so long as the partner jurisdiction continues to demonstrate firm resolve to bring the IGA into force and any information that would have been reportable under the IGA on September 30, 2015, is exchanged by September 30, 2016, together with any information that is reportable under the IGA on September 30, 2016. An IGA may significantly alter the application of FATCA and its information reporting and withholding requirements with respect to any particular investor.

FATCA is particularly complex, and its application remains uncertain. Prospective investors should consult their own tax advisors regarding how these rules may apply in their particular circumstances.

## BENEFIT PLANS AND ERISA CONSIDERATIONS

The following is a summary of certain considerations associated with the acquisition and holding of the Bonds by an employee benefit plan (as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA")) that is subject to Title I of ERISA, a benefit or retirement plan described in Section 4975 of the Code, including an individual retirement account ("IRA") or a Keogh plan, a benefit or retirement plan subject to provisions under applicable federal, state, local, non-U.S. or other laws or regulations that are similar to the provisions of Title I of ERISA or Section 4975 of the Code ("Similar Laws") and any entity whose underlying assets include "plan assets" by reason of any such employee benefit or retirement plan's investment in such entity (each of which we refer to as a "Plan").

### General Fiduciary Matters

ERISA and the Code impose certain duties on persons who are fiduciaries of a Plan subject to Title I of ERISA or Section 4975 of the Code and prohibit certain transactions involving the assets of such a Plan with its fiduciaries or other interested parties. In general, under ERISA and the Code, any person who exercises any discretionary authority or control over the administration of such a Plan or the management or disposition of the assets of such a Plan, or who renders investment advice for a fee or other compensation (direct or indirect) to such a Plan, is generally considered to be a fiduciary of the Plan.

In considering the acquisition, holding and, to the extent relevant, disposition of the Bonds with a portion of the assets of a Plan, a fiduciary should determine whether the investment is in accordance with the documents and instruments governing the Plan and the applicable provisions of ERISA and the Code relating to a fiduciary's duties to the Plan including, without limitation, the prudence, diversification, delegation of control and prohibited transaction provisions of ERISA in the Code.

Plans that are governmental plans (as defined in Section 3(32) of ERISA), certain church plans (as defined in Section 3(33) of ERISA or Section 4975(g)(3) of the Code) and non-U.S. plans (as

described in Section 4(b)(4) of ERISA) are not subject to the requirements of ERISA or Section 4975 of the Code but may be subject to similar requirements and prohibitions under Similar Laws. Accordingly, fiduciaries of such Plans shall consult with their counsel in considering whether to purchase the Bonds.

**Prohibited Transactions – In General**

Section 406 of ERISA prohibits Plans subject to ERISA from engaging in specified transactions involving plan assets with persons or entities who are "parties in interest," within the meaning of Section 3(14) of ERISA, and Section 4975 of the Code imposes an excise tax on certain "disqualified persons," within the meaning of Section 4975 of the Code, who engage in similar prohibited transactions, in each case unless an exemption is available. The definitions of "party in interest" and "disqualified person" are expansive. While other entities may be encompassed by these definitions, they include, most notably: (1) a fiduciary with respect to a Plan; (2) a person providing services to a Plan; and (3) an employer or employee organization any of whose employees or members are covered by the Plan. Certain parties in interest (or disqualified persons) that participate in a prohibited transaction may be subject to a penalty (or an excise tax) imposed pursuant to Section 502(i) of ERISA (or Section 4975 of the Code) unless a statutory or administrative exemption is available.

Certain transactions involving the purchase, holding or transfer of the Bonds might be deemed to constitute prohibited transactions under ERISA and the Code if assets of the Institution were deemed to be assets of a Plan. The U.S. Department of Labor has promulgated regulations at 29 C.F.R. Section 2510.3-101, as modified by Section 3(42) of ERISA, describing what constitutes the assets of a Plan with respect to the Plan's investment in an entity for purposes of certain provisions of ERISA and Section 4975 of the Code (the "Plan Asset Regulation").

Under the Plan Asset Regulation, the assets of the Institution would be treated as plan assets of a Plan for purposes of ERISA and the Code if the Plan acquires an "equity interest" in the Institution and none of the exceptions contained in the Plan Asset Regulation is applicable. An equity interest is defined under the Plan Asset Regulation as an interest in an entity other than an instrument which is treated as indebtedness under applicable local law and which has no substantial equity features. Although there is little statutory or regulatory guidance on this subject, and there can be no assurances in this regard, it appears that the Bonds should be treated as debt without substantial equity features for purposes of the Plan Asset Regulation. Accordingly, the assets of the Institution should not be treated as the assets of Plans investing in the Bonds. If the Institution's assets were deemed to constitute "plan assets" pursuant to the Plan Asset Regulation, transactions that the Institution might enter into, or may have entered into in the ordinary course of business, might constitute non-exempt prohibited transactions under ERISA and/or Section 4975 of the Internal Revenue Code.

**Prohibited Transaction Exemptions**

However, without regard to whether the Bonds are treated as an equity interest for such purposes, the acquisition and/or holding of any Bonds (or an interest therein) by a Plan investor with respect to which the Institution, its affiliates and other parties connected with the offering are considered a party in interest or a disqualified person may constitute or result in a direct or indirect prohibited transaction, unless the investment is acquired and is held in accordance with an applicable statutory, class or individual prohibited transaction exemption. Certain exemptions from the prohibited transaction rules recognized by the U.S. Department of Labor may be applicable depending on the type and circumstances of the Plan fiduciary making the decision to acquire a Bond. These are commonly referred to as prohibited transaction class exemptions or "PTCEs". Included among these exemptions are:

- PTCE 75-1, which excepts certain transactions between a Plan and certain broker dealers, reporting dealers and banks;

- PTCE 96-23, which exempts certain transactions effected at the sole discretion of an "in-house asset manager";

- PTCE 90-1, which exempts certain investments by "insurance company pooled separate accounts";

- PTCE 95-60, which exempts certain investments effected on behalf of an "insurance company general accounts";

- PTCE 91-38, which exempts certain investments by bank collective investment funds; and

- PTCE 84-14, which exempts certain transactions effected at the sole discretion of a "qualified professional asset manager."

Note that IRAs (and certain other plans described in Section 4975(e)(1) of the Code) are typically not represented by banks, insurance companies or registered investment advisors so that, practically speaking, these status-based PTCEs may be unavailable.

There is also a statutory exemption in Section 408(b)(17) of ERISA and Section 4975(d)(20) of the Code (which may be available to IRAs as well as to other Plans) (the "Statutory Exemption"). The Statutory Exemption covers transactions involving "adequate consideration" with persons who are parties in interest or disqualified persons solely by reason of their (or their affiliate's) status as a service provider to the Plan involved and none of which is a fiduciary with respect to the Plan assets involved (or an affiliate of such a fiduciary).

The availability of each of these PTCEs and/or the Statutory Exemption is subject to a number of important conditions which the Plan's fiduciary must consider in determining whether such exemptions apply.

Because of the foregoing, the Bonds (and any interest therein) may not be purchased or held by any person investing "plan assets" of any Plan, unless such purchase and holding will not constitute or result in a non-exempt prohibited transaction under ERISA and the Code or similar violation of any applicable Similar Laws. We cannot provide any assurance that any of the above-listed PTCEs or the Statutory Exemption will apply with respect to any particular investment in the Bonds by, or on behalf of, a Plan (or other entity deemed to hold assets of a Plan under the Plan Asset Regulation) or, even if it were deemed to apply, that any exemption would apply to all transactions that may occur in connection with the investment.

Any ERISA Plan fiduciary considering whether to purchase Bonds on behalf of an ERISA Plan should consult with its counsel regarding the applicability of the fiduciary responsibility and prohibited transaction provisions of ERISA and the Code to such investment and the availability of any of the exemptions referred to above. Persons responsible for investing the assets of Plans that are not subject to ERISA should seek similar counsel with respect to the prohibited transaction provisions of the Code and the applicability of any similar federal, state, local or foreign law.

**Representation**

It is the responsibility of each purchaser (and each subsequent transferee) of the Bonds to ensure that its purchase, holding and transfer of such Bonds is not a prohibited transaction. Each purchaser of a Bond will be deemed to have represented and warranted that either under ERISA or applicable Similar Laws (1) it is not a Plan, such as an IRA, and no portion of the assets used to acquire or hold the Bonds constitutes assets of any Plan or (2) the acquisition, holding and disposition of a Bond will not constitute a prohibited transaction under Section 406 of ERISA or Section 4975 of the Code or similar violation under any applicable Similar Laws for which there is no applicable statutory, regulatory or administrative exemption.

**The foregoing discussion is general in nature and is not intended to be all-inclusive. Due to the complexity of these rules and the penalties that may be imposed upon persons involved in non-exempt prohibited transactions, it is particularly important that fiduciaries, or other persons considering purchasing Bonds on behalf of, or with the assets of, any Plan, consult with their counsel regarding the potential applicability of ERISA, Section 4975 of the Code and any Similar Laws to such investment and whether an exemption would be applicable to the purchase and holding of the Bonds. The acquisition, holding and, to the extent relevant, disposition of the Bonds by or to any Plan is in no respect a representation by us or any of our affiliates or representatives that such an investment meets all relevant legal requirements with respect to investments by such Plans generally or any particular Plan, or that such an investment is appropriate for Plans generally or any particular Plan.**

## LITIGATION

There is no litigation pending or, to the knowledge of Mayo Clinic, threatened which could have a material adverse effect upon the operations or consolidated financial position of Mayo Clinic and its affiliates.

## LEGAL MATTERS

Certain legal matters incident to the authorization and validity of the Bonds will be passed upon by Dorsey & Whitney LLP, Minneapolis, Minnesota, Bond Counsel. Dorsey & Whitney LLP also serves as counsel to Mayo Clinic and certain of its affiliates on certain matters.

Certain legal matters in connection with the issuance of the Bonds will be passed on for Mayo Clinic by the Legal Department of Mayo Clinic, and for the Underwriters by Ballard Spahr LLP, Philadelphia, Pennsylvania.

## CERTAIN RELATIONSHIPS

Bank of America, N.A., which is the parent of Merrill Lynch, Pierce, Fenner & Smith Incorporated, an Underwriter for the Bonds, has current lending relationships with Mayo Clinic, which include standby bond purchase agreements supporting (i) $200,000,000 aggregate principal amount of the City of Rochester's Health Care Facilities Revenue Bonds (Mayo Foundation) Series 2002A, 2002B and 2002C, and (ii) $90,000,000 principal amount of The Industrial Development Authority of the City of Phoenix, Arizona Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2014A.

Wells Fargo Securities, LLC, serving as an Underwriter for the Bonds, and Wells Fargo Bank, National Association, serving as Trustee, are affiliates of each other and subsidiaries of Wells Fargo & Company. Certain subsidiaries of Wells Fargo & Company have provided, from time to time, investment

banking services, commercial banking services or other banking services to Mayo Clinic, for which they have received customary compensation. Current lending relationships between Wells Fargo Bank, National Association and Mayo Clinic include (i) a $100,000,000 line of credit supporting Mayo Clinic's self-liquidity, (ii) a $50,000,000 standby bond purchase agreement supporting like principal amount of the City of Rochester's Health Care Facilities Revenue Bonds (Mayo Foundation) Series 2000C, (iii) $15,000,000 outstanding principal amount term loan maturing in 2016 and (iv) $90,000,000 standby bond purchase agreement supporting like principal amount of The Industrial Development Authority of the City of Phoenix, Arizona Health Care Facilities Revenue Bonds (Mayo Clinic) Series 2014B.

## FINANCIAL STATEMENTS

The audited Consolidated Financial Report of Mayo Clinic as of December 31, 2015 and 2014, and for the fiscal years then ended, is included in Appendix B to this Offering Memorandum. RSM US, LLP, formerly known as McGladrey, LLP, Mayo Clinic's independent auditor, has not been engaged to perform, and has not performed, since the date of its report included herein, any procedures on the financial statements addressed in that report. RSM US, LLP also has not performed any procedures relating to this Offering Memorandum.

## FINANCIAL ADVISOR

Mayo Clinic has retained Raymond James & Associates, Inc. ("Raymond James") New York, New York, as financial advisor in connection with the issuance of the Bonds. Although Raymond James has assisted in the preparation of this Offering Memorandum, Raymond James was not and is not obligated to undertake, and has not undertaken to make, an independent verification and assumes no responsibility for the accuracy, completeness or fairness of the information contained in this Offering Memorandum.

## UNDERWRITING

Merrill Lynch, Pierce, Fenner & Smith Incorporated and Wells Fargo Securities, LLC (together, the "Underwriters") have agreed to purchase from Mayo Clinic, upon the satisfaction of certain conditions, all of the Bonds, if any are purchased, at a purchase price equal to the aggregate principal amount of the Bonds, less an underwriting discount of $_____, and will offer the Bonds initially at the offering prices stated on the front cover hereof. The Underwriters may offer and sell the Bonds to certain dealers (including depositing the Bonds into investment trusts) and to others at prices lower than the prices stated on the front cover page hereof. After the Bonds are released for sale, the public offering prices and other selling terms may from time to time be varied by the Underwriters. Mayo Clinic has agreed to indemnify the Underwriters against certain costs, claims and liabilities, including liabilities under the Securities Act of 1933, as amended, arising out of any material misstatement or omission of information in this Offering Memorandum.

The Underwriters and their respective affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, principal investment, hedging, financing and brokerage services. The Underwriters and their respective affiliates may, from time to time, perform various financial advisory and investment banking services for Mayo Clinic, for which they will receive customary fees and expenses.

In the ordinary course of their various business activities, the Underwriters and their respective affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities, which may include credit default swaps) and financial instruments (including

bank loans) for their own account and for the accounts of their customers and may at any time hold long and short positions in such securities and instruments. Such investment and securities activities may involve securities and instruments of Mayo Clinic. The Underwriters and their respective affiliates may also communicate independent investment recommendations, market color or trading ideas and/or publish or express independent research views in respect of such assets, securities or instruments and may at any time hold, or recommend to clients that they should acquire, long and/or short positions in such assets, securities and instruments.

Wells Fargo Securities is the trade name for certain securities-related capital markets and investment banking services of Wells Fargo & Company and its subsidiaries, including Wells Fargo Securities, LLC, member NYSE, FINRA, NFA, and SIPC.

## RATINGS

Moody's Investors Service ("Moody's") has assigned the Bonds a long-term rating of "___" (stable outlook), and Standard & Poor's Ratings Services, a division of The McGraw-Hill Companies, Inc. ("Standard & Poor's"), has assigned the Bonds a long-term rating of "__". These ratings address the likelihood of repayment of principal and interest when due.

Such ratings reflect only the views of Moody's and Standard & Poor's, and an explanation of the significance of such ratings may be obtained only from Moody's and Standard & Poor's. Generally, rating agencies base their ratings on the information and materials furnished to them and on investigation, studies and assumptions by the rating agencies. A securities rating is not a recommendation to buy, sell or hold securities. The ratings of the Bonds represent a judgment as to the likelihood of timely payment of the Bonds according to their terms, but do not address the likelihood of redemption prior to maturity. There is no assurance that such ratings will remain in effect for any given period of time or that any of them may not be lowered, suspended or withdrawn entirely if, in the judgment of the rating agency, circumstances so warrant. Any such downward change in or suspension or withdrawal of such ratings may have an adverse effect on the market price and marketability of the Bonds. None of Mayo Clinic or the Underwriters have undertaken any responsibility to maintain such ratings.

## MISCELLANEOUS

The references in this Offering Memorandum to the Bonds and the Indenture are brief outlines of certain provisions thereof. Such outlines do not purport to be complete and for full and complete statements of such provisions, reference is made to such instruments, documents and other materials. Copies of the foregoing documents are on file at the trust office of Wells Fargo Bank, National Association in Minneapolis, Minnesota.

The information contained in this Offering Memorandum has been compiled or prepared from information obtained from Mayo Clinic and its affiliates and other sources deemed to be reliable and, while not guaranteed as to completeness or accuracy, is believed to be correct as of this date. Any statements involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact.

Mayo Clinic has reviewed the information contained herein and the appendices hereto and has approved this Offering Memorandum.

# APPENDIX A

## Mayo Clinic and Affiliates

## Table of Contents

**Page**

# MAYO CLINIC AND AFFILIATES

## Introduction

Mayo Clinic ("Mayo Clinic" or "Mayo") is a charitable, nonprofit corporation headquartered in Rochester, Minnesota. Through Mayo Clinic related multispecialty integrated medical group practices, Mayo Medical School, Mayo Graduate School, Mayo School of Graduate Medical Education, Mayo School of Health Sciences and Mayo School of Continuous Professional Development and its other divisions and affiliates, Mayo Clinic provides comprehensive medical care, education in clinical medicine and the medical sciences, and extensive programs in medical research. Mayo Clinic and its affiliated corporations (described below) comprise one of the largest medical institutions in the world.

Mayo Clinic developed from the medical practice of a pioneer physician, Dr. William Worrall Mayo. Born in 1819 near Manchester, England, Dr. Mayo came to America at the age of 25. Following a series of westward moves, Dr. Mayo was appointed in 1863 as examining surgeon for the Union Army Enrollment Board in Rochester, Minnesota. A tornado devastated Rochester in 1883. During the emergency, the Sisters of Saint Francis provided nursing care at the request of Dr. Mayo. The disaster produced a working relationship that led to the construction of Saint Marys Hospital in 1889. Dr. Mayo, with his sons, William James Mayo and Charles Horace Mayo, comprised the medical staff of the new 27 bed hospital. As the number of patients increased, more physicians joined the practice that eventually assumed the name Mayo Clinic. In 1919, the Mayo brothers founded the Mayo Properties Association, transferred to it all properties and facilities, the name Mayo Clinic, and the right to receive all future earnings of Mayo Clinic. In May 1986, the corporate predecessor to Mayo Clinic formalized its affiliation with Mayo Clinic-Saint Marys Hospital ("Mayo Clinic-Saint Marys" or "Saint Marys") and Mayo Clinic-Methodist Hospital ("Mayo Clinic-Methodist" or "Methodist") with the signing of an integration agreement. As of January 1, 2014, Mayo Clinic-Saint Marys and Mayo Clinic-Methodist merged to form Mayo Clinic Hospital-Rochester ("Mayo Clinic Hospital-Rochester"). Mayo Clinic and Mayo Clinic Hospital-Rochester together comprise one of the world's largest private medical complexes.

In addition to their clinical medical practice, the Doctors Mayo established a center for medical education and research. In 1915, with an initial gift of $1,500,000, the Mayo brothers established the Mayo Graduate School of Medicine (now known as Mayo School of Graduate Medical Education), which offers graduate residency training for physicians and scientists working toward certification as specialists of medicine and surgery, as well as fellowships for those planning research and teaching careers in the medical sciences. Approximately 20,000 physicians, practicing throughout the United States and 75 foreign countries, are members of the alumni association of the Mayo School of Graduate Medical Education.

Mayo Clinic is also the sole member or shareholder of separately incorporated entities which, as described below, offer products and services related to, derived from, or in support of, Mayo Clinic's medical practice, education and research missions.

## Mayo Clinic Principles

Mayo Clinic has developed a set of principles to guide its activities.

*Mission*

To inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research.

*Primary Value*

The needs of the patient come first.

*Value Statements*

These values, which guide Mayo Clinic's mission to this day, are an expression of the vision and intent of our founders, the original Mayo physicians and the Sisters of Saint Francis.

- Respect – Treat everyone in our diverse community, including patients, their families and colleagues, with dignity.

- Compassion – Provide the best care, treating patients and family members with sensitivity and empathy.

- Integrity – Adhere to the highest standards of professionalism, ethics and personal responsibility, worthy of the trust our patients place in us.

- Healing – Inspire hope and nurture the well-being of the whole person, respecting physical, emotional and spiritual needs.

- Teamwork – Value the contributions of all, blending the skills of individual staff members in unsurpassed collaboration.

- Excellence – Deliver the best outcomes and highest quality service through the dedicated effort of every team member.

- Innovation – Infuse and energize the organization, enhancing the lives of those we serve, through the creative ideas and unique talents of each employee.

- Stewardship – Sustain and reinvest in our mission and extended communities by wisely managing our human, natural and material resources.

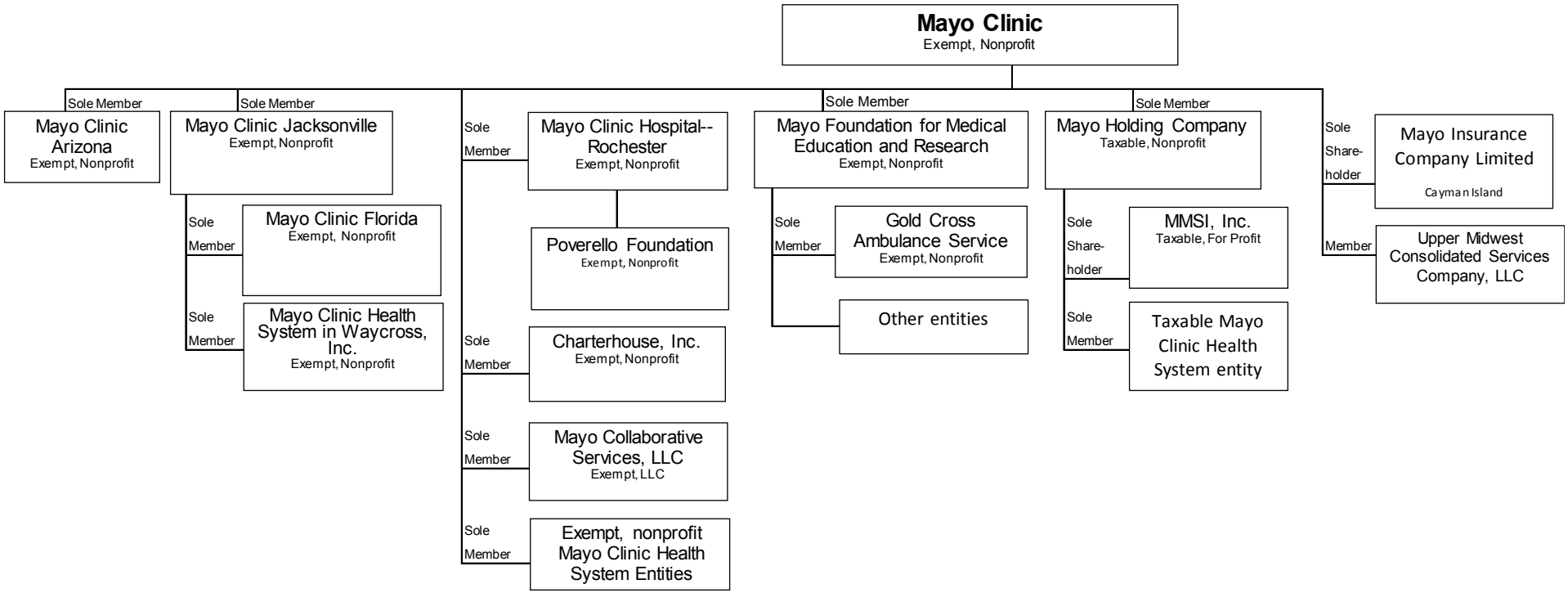
**Corporate Organization**

*Mayo Clinic*

Mayo Clinic is a Minnesota nonprofit corporation and an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), that is not a private foundation under Section 509(a) of the Code.

Mayo Clinic's educational activities – collectively known as the Mayo Clinic College of Medicine – are conducted by Mayo Graduate School, Mayo School of Graduate Medical Education, Mayo Medical School, Mayo School of Health Sciences and Mayo School of Continuous Professional Development, all of which operate as divisions of Mayo Clinic itself. Mayo Graduate School offers training leading to the granting of M.S. and Ph.D. degrees in biomedical sciences for students planning research careers. Mayo School of Graduate Medical Education provides residency training for physicians pursuing specialist certification. Mayo Medical School offers a four year program leading to an M.D. degree. Mayo School of Health Sciences conducts training programs for physical therapists, nurse anesthetists, occupational therapists, medical laboratory technicians, diagnostic and therapeutic radiology technicians and other allied health personnel. Mayo School of Continuous Professional Development provides ongoing education for physicians and other health care professionals through conferences and visits to Mayo facilities.

An abbreviated organizational chart showing the current relationship between Mayo Clinic and certain affiliated corporations is set forth on the following page.


Mayo Clinic
Exempt, Nonprofit
Sole Member
Mayo Clinic Arizona
Exempt, Nonprofit
Sole Member
Mayo Clinic Jacksonville
Exempt, Nonprofit
Sole Member
Mayo Clinic Florida
Exempt, Nonprofit
Sole Member
Mayo Clinic Health System in Waycross, Inc.
Exempt, Nonprofit
Sole Member
Mayo Clinic Hospital--Rochester
Exempt, Nonprofit
Poverello Foundation
Exempt, Nonprofit
Sole Member
Charterhouse, Inc.
Exempt, Nonprofit
Sole Member
Mayo Collaborative Services, LLC
Exempt, LLC
Sole Member
Exempt, nonprofit Mayo Clinic Health System Entities
Sole Member
Mayo Foundation for Medical Education and Research
Exempt, Nonprofit
Sole Member
Gold Cross Ambulance Service
Exempt, Nonprofit
Other entities
Sole Member
Mayo Holding Company
Taxable, Nonprofit
Sole Shareholder
MMSI, Inc.
Taxable, For Profit
Sole Member
Taxable Mayo Clinic Health System entity
Sole Shareholder
Mayo Insurance Company Limited
Cayman Island
Member
Upper Midwest Consolidated Services Company, LLC

*Affiliated Corporations*

Mayo Clinic is the direct or indirect corporate parent of several corporations, including those described below, and operates a coordinated and integrated medical group practice in Rochester, Minnesota. Mayo Clinic and Mayo Clinic Hospital-Rochester (see below) together comprise one of the world's largest private medical complexes. As of December 31, 2015, Mayo Clinic had 2,361 staff physicians and scientists at its Rochester medical facilities. Mayo Clinic also conducts extensive programs in medical research and education.

Mayo Clinic Hospital-Rochester. Mayo Clinic Hospital-Rochester owns and operates a tertiary care hospital located on two campuses with a licensed capacity of 2,059 beds staffed exclusively by Mayo Clinic physicians. Mayo Clinic Hospital-Rochester is a Minnesota nonprofit corporation and an organization described in Section 501(c)(3) of the Code.

Mayo Clinic Jacksonville. Mayo Clinic Jacksonville is a Florida nonprofit corporation and an organization described in Section 501(c)(3) of the Code. Mayo Clinic Jacksonville is located in Jacksonville, Florida, where it operates a multispecialty, integrated medical group practice and conducts extensive programs in medical education and research. Mayo Clinic Jacksonville is the sole member of Mayo Clinic Florida, a Florida nonprofit corporation and an organization described in Section 501(c)(3) of the Code that owns and operates a 304 bed teaching and research hospital on its campus staffed exclusively by Mayo Clinic physicians. As of December 31, 2015, Mayo Clinic Jacksonville had 497 staff physicians. Mayo Clinic Jacksonville also operates three family medicine and primary care clinics, two in the Jacksonville area and the other in St. Augustine, Florida.

On March 1, 2012, Satilla Health Services Inc. became a controlled affiliate of Mayo Clinic Jacksonville, and is now known as Mayo Clinic Health System in Waycross, Inc. ("MCHSW"). MCHSW, a Georgia nonprofit corporation and an organization described in Section 501(c)(3) of the Code, operates a 231 licensed bed acute care hospital, with 189 beds available as of December 31, 2015, as well as a skilled nursing facility and related facilities located in Waycross, Georgia, approximately 85 miles from Mayo Clinic Jacksonville's facilities.

Mayo Clinic announced it intends to end the integration agreement with MCHSW and return governance to the local community directors. See "Mayo Clinic Health System – Mayo Clinic Affiliated Hospitals – Mayo Clinic Florida" below.

Mayo Clinic Arizona. Mayo Clinic Arizona is an Arizona nonprofit corporation and an organization described in Section 501(c)(3) of the Code. Mayo Clinic Arizona operates a multi-specialty, integrated medical group practice in Scottsdale and Phoenix, Arizona, and conducts extensive programs in medical education and research. As of December 31, 2015, Mayo Clinic Arizona had 456 staff physicians. Mayo Clinic Arizona also owns and operates a 268 bed acute care hospital in Phoenix, Arizona staffed exclusively by Mayo physicians.

Mayo Foundation for Medical Education and Research ("MFMER"). Mayo Foundation for Medical Education and Research is a Minnesota nonprofit corporation and an organization described in Section 501(c)(3) of the Code. MFMER has operating divisions involved in the following activities: publication of health information; provision of health guidance; development and licensing of medically-related products; pharmacy operations; and shared administrative support services including finance, planning, supply chain, revenue cycle and information technology services.

MFMER conducts education and health and wellness activities through several businesses. Revenue generated in excess of operational and re-investment needs is returned to Mayo Clinic to further its

mission of healing the sick, advancing medical science, and training the next generation of medical professionals. These activities include:

- Medical Products, which provides medical supplies and pharmaceutical services to Mayo Clinic patients, employees, dependents and retirees by means of outpatient pharmacies, a specialty and mail order pharmacy and three medical supply stores.

- Mayo Clinic Ventures, which works with inventors and industry to move innovations from bench to bedside by creating new licensing opportunities, new companies and new products. Mayo Clinic Ventures has filed more than 6,000 patent applications resulting in more than 750 active license agreements with companies in the biomedical and manufacturing industries.

MFMER is the sole corporate member of Gold Cross Ambulance Service, a Minnesota nonprofit corporation that, together with its related entities, provides ground ambulance services to 18 Minnesota counties and three Wisconsin counties.

Mayo Holding Company ("MHC"). MHC is a taxable nonprofit Minnesota corporation that serves as the parent holding company for the majority of Mayo Clinic's taxable subsidiaries.

MHC is the corporate parent of MMSI, Inc., a health benefit management company which provides third party administration services for corporate and government clients, including Mayo Clinic. MMSI processes claims, manages provider networks and provides professional services such as utilization management and case management.

Mayo Clinic Global Business Solutions ("GBS"). GBS is a business unit responsible for developing, managing and overseeing an integrated, global business strategy that extends Mayo Clinic's reach to patients, providers and consumers around the world. GBS includes initiatives originating in MFMER and MHC, and brings together the staff, resources and service lines encompassing the web, mobile, print and telephonic channels that make Mayo Clinic's health information and health guidance and unique model of care available to millions of people world-wide.

Mayo Clinic Health System. Mayo Clinic or one of its affiliates is the corporate parent of 10 nonprofit corporations that operate primary and secondary care clinics located in over 70 communities in southern Minnesota, northern Iowa and western Wisconsin. As of December 31, 2015, these regional clinics employed 950 full-time equivalent physicians predominantly in primary care. Mayo Clinic or one of its affiliates also is the corporate parent of 18 hospitals in the same region with a total of 1,457 licensed beds. This combined network is known as the Mayo Clinic Health System. The local board of directors of each regional practice within Mayo Clinic Health System has substantial authority to make operational decisions. However, Mayo Clinic and affiliates guide the overall direction and assist with the integration of various components of Mayo Clinic Health System, and Mayo Clinic or one of its affiliates has the right to appoint and remove a majority of the local directors and to approve such actions as the incurrence of significant amounts of debt.

Mayo Clinic may add other affiliated clinics and hospitals in the future as part of its regional strategy to develop an integrated, geographically distributed provider network in an approximately 120-mile radius of Rochester, Minnesota. In connection with affiliating with other clinics and hospitals, Mayo Clinic may from time to time assume or guarantee indebtedness of the entities with which it affiliates.

Other Relationships. Mayo Clinic is also the corporate parent of a number of separately incorporated entities that offer products and services related to, derived from, or in support of Mayo Clinic's medical practice, education and research missions. These include, among others:

- Mayo Collaborative Services LLC ("MCS"). MCS, d/b/a Mayo Medical Laboratories, provides extensive laboratory services and specialty outreach services to physicians, hospitals, and healthcare companies throughout the United States and abroad. Mayo Clinic is the sole member of MCS.

- Mayo Insurance Company Limited. Mayo Insurance Company Limited is a captive offshore insurance company that provides general and professional liability insurance for Mayo Clinic-affiliated physicians and hospitals.

- Charterhouse Inc. Charterhouse Inc. operates Charter House, a continuing care retirement community located in Rochester, Minnesota that offers a total of 309 apartment and assisted living units and 32 skilled nursing beds. As of December 31, 2015, the apartment units, assisted living units and the skilled nursing facility beds were approximately 88% occupied.

- Upper Midwest Consolidated Services Center, LLC ("Upper Midwest"). Mayo Clinic (along with other midwest health care providers) is a member of Upper Midwest, a limited liability company which provides healthcare supply and purchasing services for its members aimed at reducing its members' supply-related payment costs and inventories.

**Governance**

Mayo Clinic is governed by a Board of Trustees consisting of public members with a broad range of backgrounds and interests, Mayo Clinic physicians (designated as "Consultants") and administrators. In its role as direct or indirect corporate parent, Mayo Clinic has the power to appoint and remove a majority of the members of the governing boards of its subsidiaries and, as a matter of current corporate policy, also must approve certain activities of its subsidiaries such as incurring significant amounts of debt, transferring significant assets, encumbering property or undertaking mergers or similar types of reorganizations. The Mayo Clinic Board of Governors is the executive committee of the Board of Trustees. The Board of Governors is currently composed of eleven Consultants and three administrators and is responsible for the day-to-day management and operations of Mayo Clinic. Mayo Clinic's Board of Trustees meets quarterly and is comprised of the individuals shown below.

| Name | Past/Present Business Affiliation or Occupation | Date on Board | Expiration of Current Term |
|---|---|---|---|
| ***Public Trustees*** | | | |
| Linda G. Alvarado | President and Chief Executive Officer<br>Alvarado Construction, Inc.<br>Denver, CO | May, 2012 | 2020 |
| Bradbury H. (Brad) Anderson | Retired CEO and Vice Chairman<br>Best Buy Co., Inc.<br>Richfield, MN | Feb., 2009 | 2017 |
| Anne M. Sweeney | Former President<br>Disney/ABC Television Group<br>Burbank, CA | Feb., 2016 | 2020 |
| Armando Codina | Chairman & CEO<br>Codina Partners, LLC<br>Coral Gables, FL | May, 2014 | 2018 |

| Name | Past/Present Business Affiliation or Occupation | Date on Board | Expiration of Current Term |
|---|---|---|---|
| Mary Sue Coleman, Ph.D. | President Emerita<br>University of Michigan | Nov., 2014 | 2019 |
| Samuel A. Di Piazza, Jr.<br>Chair, Board of Trustees | Retired Global CEO<br>PricewaterhouseCoopers International Limited<br>New York, NY | Aug., 2010 | 2018 |
| Michael E. Dougherty | Chairman<br>Dougherty Financial Group LLC<br>Minneapolis, MN | Nov., 2012 | 2017 |
| William W. (Bill) George | Professor of Management Practice<br>Harvard Business School<br>Cambridge, MA | Feb., 2012 | 2018 |
| George C. Halvorson | Retired Chairman & CEO<br>Kaiser Foundation Health Plan, Inc.<br>Oakland, CA | Feb., 2014 | 2018 |
| Roy A. Herberger, Jr., Ph.D. | President Emeritus<br>Thunderbird School of Global Management<br>Phoenix, AZ | May, 2006 | 2018 |
| Cokie Roberts | Political Analyst<br>ABC News and National Public Radio<br>Washington, DC | Feb., 2016 | 2020 |
| Aulana L. Peters | Retired Partner<br>Gibson, Dunn & Crutcher LLP<br>Los Angeles, CA | Feb., 2007 | 2017 |
| Kenneth L. Salazar | Partner<br>Wilmer Hale<br>Washington, DC | Feb., 2016 | 2020 |
| Michael K. Powell | President & CEO<br>National Cable and Telecommunications Association<br>Washington, DC | Feb., 2011 | 2019 |
| Eric E. Schmidt, Ph.D. | Executive Chairman<br>Google, Inc.<br>Mountain View, CA | Nov., 2013 | 2018 |
| Randolph C. Steer, M.D., Ph.D. | Independent Biotechnology Consultant<br>Desert Health Enterprises<br>Rancho Mirage, CA | Nov., 2011 | 2020 |
| Diana L. Taylor | Managing Director<br>Wolfensohn Fund Management<br>New York, NY | May, 2014 | 2018 |

| Name | Past/Present Business Affiliation or Occupation | Date on Board | Expiration of Current Term |
|---|---|---|---|
| Charles B. Tomm, J.D. | President & CEO<br>The Brumos Companies<br>Jacksonville, FL | May, 2013 | 2017 |
| ***Internal Trustees*** | | | |
| Daniel J. Berry, M.D.* | Chair, Department of Orthopedic Surgery<br>Consultant, Orthopedics<br>Mayo Clinic<br>Rochester, MN | 2013 | 2017 |
| Jeffrey W. Bolton* | Vice President, Administration<br>Mayo Clinic<br>Rochester, MN | 2011 | Ex-Officio |
| Steven J. Buskirk, M.D.* | Chair, Radiation Oncology Department<br>Consultant, Radiation Oncology<br>Mayo Clinic Jacksonville<br>Jacksonville, FL | 2012 | 2020 |
| Wyatt W. Decker, M.D.* | Vice President, Mayo Clinic<br>Chief Executive Officer, Mayo Clinic Arizona<br>Phoenix/Scottsdale, AZ | 2011 | Ex-Officio |
| Gianrico Farrugia, M.D.* | Vice President, Mayo Clinic<br>Chief Executive Officer, Mayo Clinic Jacksonville<br>Jacksonville, FL | 2015 | Ex-Officio |
| Bobbie S. Gostout, M.D.* | Vice President, Mayo Clinic<br>Chair, Department of Obstetrics & Gynecology<br>Consultant, Gynecologic Oncologist<br>Mayo Clinic<br>Rochester, MN | 2014 | Ex-Officio |
| Eddie L. Greene, M.D.* | Consultant, Nephrology<br>Mayo Clinic<br>Rochester, MN | 2014 | 2018 |
| C. M. (Michel) Harper, Jr., M.D.* | Executive Dean for Practice<br>Consultant, Neurology<br>Mayo Clinic<br>Rochester, MN | 2014 | 2018 |
| Lois E. Krahn, M.D.* | Consultant, Psychiatry<br>Mayo Clinic Arizona<br>Phoenix/Scottsdale, AZ | 2013 | 2017 |
| Paula E. Menkosky | Chief Administrative Officer<br>Mayo Clinic in Arizona<br>Phoenix/Scottsdale, AZ | 2016 | 2017 |

| Name | Past/Present Business Affiliation or Occupation | Date on Board | Expiration of Current Term |
|---|---|---|---|
| Dawn S. Milliner, M.D.* | Consultant, Nephrology<br>Mayo Clinic<br>Rochester, MN | 2009 | 2017 |
| John H. Noseworthy, M.D.* | President and Chief Executive Officer<br>Mayo Clinic<br>Rochester, MN | 2009 | Ex-Officio |
| Veronique L. Roger, M.D.* | Consultant, Cardiovascular<br>Mayo Clinic<br>Rochester, MN | 2011 | 2019 |
| Mary Jo Williamson* | Chair, Department of Practice Administration<br>Mayo Clinic<br>Rochester, MN | 2013 | 2018 |

*Member of the Mayo Clinic Board of Governors.

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***Emeritus Public Trustees (Non-Voting)***

Lilyan H. Affinito
Robert E. Allen
H. Brewster Atwater, Jr.
Hon. Howard H. Baker, Jr.
James L. Barksdale
Barbara M. Barrett
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Hugh R. Price
Lee R. Raymond, Ph.D.
Frederick W. Smith
Donald M. Stewart, D.P.A.
Anne M. Tatlock
Paul A. Volcker
Robert C. Winters
Elias A. Zerhouni, M.D.

**Management**

The principal officers of Mayo Clinic and certain biographical information regarding these individuals are set forth below:

**John H. Noseworthy, M.D. (Age 64), President and Chief Executive Officer**

*Experience*. Assistant Professor, Department of Clinical Neurological Sciences, University of Western Ontario, 1983; Assistant Director, Multiple Sclerosis Clinic, University of Western Ontario, 1985; Associate Professor, Department of Clinical Neurological Sciences, University of Western Ontario, 1989; Senior Associate Consultant, Department of Neurology, Mayo Clinic, 1990-1992; Associate Professor of Neurology, Mayo Clinic College of Medicine, 1990-1994; Professor of Neurology, Mayo Clinic, 1994-present; Head of Section, Department of Neurology, Mayo Clinic, 1992-1997; Chair of the Division of Neuroimmunology, Mayo Clinic, 1994-1997; Vice Chair, Research, Department of Neurology, Mayo Clinic, 1994-1997; Chair of the Department of Neurology, Mayo Clinic, 1997-2006; Medical Director – Department of Development, Mayo Clinic, 2006-2009; Editor-in-Chief, NEUROLOGY, 2007-2009; Mayo Clinic Board of Trustees, 2009-present; President and Chief Executive Officer, Mayo Clinic, 2009-present.

*Education*. Dalhousie University, Halifax, Nova Scotia, M.D., 1975, Residency in Internal Medicine, 1977-1979, Chief Resident Internal Medicine, 1978, Residency in Neurology, 1979; Royal College of Physicians and Surgeons of Canada, Fellowship in Neurology, 1981; University of Western Ontario, Residency in Neurology, 1980, Residency in Neuropathology, 1981; University Hospital, London Ontario, Residency in Neuroimmunology Laboratory, 1981; Harvard Medical School, Research

Fellowship in Pathology, 1981-1983; Massachusetts General Hospital, Harvard University, Research Fellowship in Neurology, 1983.

**Jeffrey W. Bolton (Age 60), Vice President, Administration**

*Experience.* City of Pittsburgh, Contract Administrator, 1979-1981; University of Pittsburgh, Planning and Financial Analyst, 1981-1984; Carnegie Mellon University, Assistant Director for Institutional Research, 1984-1988; Director of University Planning, 1988-1991; Assistant Vice President for Planning and Budget, 1991-1995; Vice President for Planning and Budget 1995-1998; Vice President for Business and Planning and CFO, 1998-2002; Mayo Clinic, Chief Financial Officer, 2002-2013; Vice President, Administration, 2013-present; Mayo Clinic Board of Trustees, 2011-present.

*Education.* Pennsylvania State University, 1977, B.A.; University of Pittsburgh, M.S.W., 1979, M.B.A., 1987.

*Professional Organizations and Other Activities*. Member American Medical Group Association; Member Financial Executives Institute; Vizient, Board Member; Resoundant, Inc., Board Member; Destination Medical Center and Economic Development Board, Chair; Past Board Member Rochester Family Service, Chair Finance Committee; Past Officer, Carnegie Mellon University Board of Trustees; Past Treasurer/Secretary, Carnegie Technology Education; Past Vice Chair, Holy Family Institute; Past Board Member, Pennsylvania Economy League; Past Board Member, Pittsburgh Civic Light Opera; Past President, Schenley Golf Operating Corporation; Past Member, Fidelity Client Advisory Board, Bellefield Power Plant.

**Gianrico Farrugia, M.D. (Age 52), Vice President of Mayo Clinic and CEO of Mayo Clinic in Florida**

*Experience.* Senior Associate Consultant, Division of Gastroenterology and Internal Medicine, Mayo Foundation, 1994-1997; Senior Associate Consultant, Department of Physiology and Biomedical Engineering (joint appointment), Mayo Clinic, 1996-1997; Assistant Professor of Physiology and Biomedical Engineering, Mayo Medical School, 1994-1999; Assistant Professor of Medicine, Mayo Medical School, 1994-2000; Associate Professor of Medicine, Mayo Clinic College of Medicine, 2000-2004; Associate Professor of Physiology and Biomedical Engineering, Mayo Clinic College of Medicine, 2000-2004; Consultant, Division of Gastroenterology and Hepatology and Internal Medicine, Mayo Clinic College of Medicine, 1997-current; Consultant, Department of Physiology and Biomedical Engineering, Mayo Clinic College of Medicine, 1996-current; Research Chair, Division of Gastroenterology & Hepatology, Mayo Clinic, 2000-2005; Chair, Research Space and Equipment Subcommittee, Mayo Clinic, 2003-2006; Professor of Medicine, Mayo Clinic College of Medicine, 2004-current; Professor of Physiology and Biomedical Engineering, Mayo Clinic College of Medicine, 2004-current; Director, Enteric NeuroScience Program, Mayo Clinic College of Medicine, 2004-present; Director, Motility Interest Group, Mayo Clinic College of Medicine, 2006-2010; Associate Chair, Research, Department of Medicine, Mayo Clinic, 2008-2011; Associate Director, Mayo Center for Cell Signaling in Gastroenterology and Director of the Pilot and Feasibility Program, 2009-2014; Associate Medical Director, Mayo Clinic Center for Innovation, 2010 – 2014; Director, Mayo Clinic Center for Individualized Medicine, 2011 - 2014; President-Elect, American Neurogastroenterology and Motility Society, 2014-2015; President, American Neurogastroenterology and Motility Society, 2015-2017; Vice President, Mayo Clinic, 2015-current; Chief Executive Officer, Mayo Clinic in Florida, 2015-current.

*Education.* St. Aloysius College, B'Kara, Malta, B.S., (1981); University of Malta Medical School, M.D.,(1987); Internship in St. Lukes University Hospital, G'Mangia, Malta (1987-1988); Internship in Department of Internal Medicine, Mayo Graduate School of Medicine (1988-1989); Residency in Department of Internal Medicine, Mayo Graduate School of Medicine, Rochester, MN (1989-1991);

Fellowship in Clinician-Investigator Fellow, Division of Gastroenterology, Mayo Graduate School of Medicine (1991-1994); Clinical Investigator Fellowship, Department of Physiology & Biomedical Engineering, Mayo Clinic, Rochester, MN (1991-1993); Mayo Foundation CR75, Department of Medicine, Division of Gastroenterology, Mayo Graduate School of Medicine (1993-1996);

*Professional Organizations and Other Activities.* Zumbro Valley Medical Association, 1988; Minnesota Medical Association, 1988; American Medical Association, 1988; American College of Physicians, 1991; International Motility Society, 1992; American College of Gastroenterology, 1992; American Motility Society, 1993; American Gastroenterological Association, 1993; American Society for Gastrointestinal Endoscopy, 1996; American Federation of Research, 1998; American Physiological Society, 2000; American Society for Clinical Investigation, 2005; Association of Gastrointestinal Motility Disorders, 2005; Duval Medical Society, 2015; NeuroGastroenterology and Motility, Editorial Board, 2001-2010; American Journal of Physiology: Gastrointestinal & Liver Physiology, Editorial Board, 2003-current; Faculty of 1000 Biology's Physiology (on-line), Editorial Board, 2005-2010; Gastroenterology, Guest Associate Editor, 2008-current; Neurogastroenterology and Motility, Basic Science Editor, 2011-2014; Cellular and Molecular Gastroenterology and Hepatology, Editorial Board, 2014-current; Vanderbilt Digestive Disease Research Center, Advisory Board, 2001-2010; International Steering Committee of the International Group for the Study of Gastrointestinal Motility, 2005-2011; International Foundation for Functional Gastrointestinal Disorders, 2008-2014; Ernst & Young's Life Sciences Advisory Board, 2010-2013; Rock Health, Mayo Clinic Medical Advisor, 2012-2014; Oncospire Scientific, Advisory Board Chair, 2013-2014.

**Wyatt W. Decker, M.D., M.B.A. (Age 53), Vice President, Mayo Clinic and Chief Executive Officer, Mayo Clinic Arizona**

*Experience.* Research Assistant, Ovarian Cancer Lab, Linus Pauling Institute of Science and Medicine, Palo Alto, CA, 1985-86; Mountaineering Instructor, National Outdoor Leadership School, Lander, WY, 1985-86; Research Fellowship, Institute of Medical Research, Goroka, Papua New Guinea, 1989; Ronald Regan Fellowship, Emergency Department, Chang Gung Memorial Hospital, Taipei, Taiwan, 1995; Consultant, Department of Emergency Medicine, Mayo Clinic, MN, 1996-2011Program Director, Emergency Medicine Residency Program, Mayo School of Graduate Medical Education, 1997-2003; Assistant Editor, Mayo Clinic Family Health Book, 2003-2006; Chair, Department of Emergency Medicine, Mayo Clinic, 2000-2009; Chair, Department of Emergency Medicine, Mayo Clinic, Jacksonville, FL, 2005-2008; Editor-in-Chief; International Journal of Emergency Medicine, 2008-2011; Professor of Emergency Medicine, College of Medicine, Mayo Clinic, 2009-present; Vice President, Mayo Clinic, 2011- present; Chief Executive Officer, Mayo Clinic in Arizona; 2011-present;

*Education.* University of California, Santa Cruz, B.A., 1986; Mayo Medical School, M.D., 1990; Mayo School of Graduate Medical Education, College of Medicine, Mayo Clinic, Residency in Internal Medicine, 1990-93; Denver Health and Hospitals, Residency in Emergency Medicine, 1993-96; Northwestern University, Kellogg School of Management, MBA, 2011.

*Professional Organizations and Other Activities.* American College of Emergency Physicians, Fellow (1999-present); Foundation for Education and Research in Neurological Emergencies, Advisory Board Member, 2006-2011; Greater Phoenix Leadership, Greater Phoenix Economic Council, Arizona Bioscience Roadmap Steering Committee, Arizona Chamber of Commerce and Industry Board of Directors, 2011-present.

**Bobbie S. Gostout, M.D. (Age 60), Vice President, Mayo Clinic**

*Experience*. Senior Associate Consultant - Department of Obstetrics & Gynecology, Mayo Clinic, Rochester, Minnesota 1996-1999; Assistant Professor of Obstetrics and Gynecology - Mayo Clinic College of Medicine, 1996-2004; Associate Professor of Obstetrics and Gynecology - Mayo Clinic College of Medicine 2004-2012; Consultant - Division of Gynecologic Surgery, Department of Obstetrics & Gynecology, Mayo Clinic, Rochester, Minnesota 1999-present; Chair - Department of Obstetrics & Gynecology, Mayo Clinic, Rochester, Minnesota 2007-present; Consultant (Joint Appointment) - Department of Surgery, Mayo Clinic, Rochester, Minnesota 2012-present; Mayo Clinic Board of Governors 2014-present; Professor of Obstetrics and Gynecology - Mayo Clinic College of Medicine 2012-present; Vice President Mayo Clinic, Rochester, Minnesota 2015-present.

*Education*. College of St. Teresa (1974-1978), BS, Nursing; St. Mary's College (1979-1981) Biology; Mayo Medical School, Mayo Clinic College of Medicine (1982-1986) MD; Mayo Graduate School of Medicine, Mayo Clinic College of Medicine - Resident, Internal Medicine (1986-1987); Mayo Graduate School of Medicine, Mayo Clinic College of Medicine - Resident, Obstetrics and Gynecology (1987-1991); Mayo Graduate School of Medicine, Mayo Clinic College of Medicine - Research Fellowship, Obstetrics and Gynecology (1991-1993); Mayo Graduate School of Medicine, Mayo Clinic College of Medicine - Fellow, Gynecologic Oncology (1993-1996).

**Kedrick D. Adkins (Age 63), Chief Financial Officer**

*Experience.* Accenture, Progression from Analyst through Senior Manager, 1976-1986; Accenture, Partner, Health Care Practice, 1986-1998; Accenture, Managing Partner, Western Region Health Care Practice, 1998-2004; Accenture, Global Managing Partner, Health Care Practice, 2004-2005; Accenture, Global Chief Diversity Officer and Country Managing Direct, US Operations, 2005-2007; Trinity Health, President of Integrated Services, 2007-2013; CHE-Trinity, Inc., Chief Financial Officer, 2013-2014; Mayo Clinic, Chief Financial Officer, effective May 9, 2014-Present.

*Education.* University of Michigan, Ann Arbor, 1974, B.S., Engineering; University of Michigan, Ann Arbor, 1976, M.B.A., Finance and Accounting.

*Professional Organizations and Other Activities.* Certified Public Accountant; Blue Cross Blue Shield of Michigan's Blue Care Network, Board Member; American Hospital Association Health Forum, Board Member; Health Insights, Member; Accenture National Quality Award; Industrial and Operations Engineering Society's Merit Award, University of Michigan, 2008; University of Michigan College of Engineering, Corporate Advisory Council; University of Michigan Alumni Association, Board Member; White House Fellowship Finalist; "40 under 40" for Metropolitan Detroit; Eagle Scout; Published author of numerous healthcare articles; Past speaker for industry and academic groups including the Health Care Financial Management Association, American Association of Health Plans, Health Insurance Association of America, and the University of Michigan Industrial and Operations Engineering Society.

**Joshua B. Murphy (Age 50), Chief Legal Officer and Corporate Secretary**

*Experience*. Attorney, Segal McCambridge Singer & Mahoney, 1993-2000; Legal Counsel, Mayo Clinic, 2000-2010; Associate Chief Legal Officer, Mayo Clinic, 2010-2015; Chief Legal Officer and Corporate Secretary, Mayo Clinic, February 2015-present.

*Education*. Amherst College, B.A., 1988; Northwestern University School of Law, J.D., *cum laude*, 1993.

**Harry N. Hoffman (Age 60), Treasurer and Co-Chief Investment Officer**

*Experience*. Office of Congressman Bruce F. Vento, Washington, D.C., Legislative Aide, 1980-1982; Group Health Inc., Minneapolis, Minnesota, Financial Analyst, 1984-1985; Dain Bosworth, Inc., Associate – Public Finance Department, 1985-1987; Springsted Incorporated, St. Paul, Minnesota, Public Finance Project Manager, 1987-1990; Mayo Clinic, Department of Finance, 1990-present; Analyst, Financial Planning and Analysis, 1990-1993; Treasury Services, Section Head 1993-present; Mayo Clinic, Assistant Treasurer, 1996-2003; Chief Investment Officer, 2001-present; Treasurer, 2003-present.

*Education*. University of Minnesota, B.A., 1978; Yale School of Management, M.B.A., 1984.

*Professional Organizations and Other Activities.* Director, Okabena Company, 2010-2015; Emeritus Trustee, Endowment Fund of the American Red Cross, 2002-2010 and chair, 2006-2010; Emeritus Trustee, The Investment Fund for Foundations (TIFF), 2001-2007; Emeritus Trustee, Ronald McDonald House of Rochester, Minnesota, 1999-2005.

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**Description of Clinic Activities**

*Clinical Practice Activities*

Mayo Clinic, Mayo Clinic Arizona and Mayo Clinic Jacksonville operate coordinated and integrated group practices in three sites: Rochester, Minnesota; Scottsdale and Phoenix, Arizona; and Jacksonville, Florida. All employees of these three entities, including staff physicians and scientists (designated as "Consultants" below) receive compensation in the form of salaries. The following tables provide summaries of information concerning Mayo's practice activities in Rochester, Florida and Arizona. Information on affiliated regional practices can be found below under "– Mayo Clinic Health System."

**Consulting Staff as of December 31, 2015**
**Mayo Clinic**

**Rochester, Florida and Arizona**

| Department/Division | Rochester | Florida | Arizona | Total |
|---|---|---|---|---|
| Internal Medicine | | | | |
| Allergic Diseases | 10 | 2 | 3 | 15 |
| Cardiovascular Diseases | 160 | 19 | 24 | 203 |
| Emergency Room | 56 | 19 | 16 | 91 |
| Endocrinology | 45 | 5 | 5 | 55 |
| Gastroenterology | 90 | 20 | 20 | 130 |
| Hematology* | 54 | 21 | 24 | 99 |
| Hypertension* | – | 4 | – | 4 |
| Infectious Diseases | 28 | 6 | 4 | 38 |
| Nephrology | 42 | – | 3 | 45 |
| Rheumatology | 18 | 4 | 3 | 25 |
| Thoracic Diseases | 54 | 10 | 6 | 70 |
| General Internal Medicine | 215 | 39 | 60 | 314 |
| Sub-Total | 772 | 149 | 168 | 1,089 |
| Medical Specialties | | | | |
| Dermatology | 32 | 9 | 7 | 48 |
| Diagnostic Radiology | 233 | 42 | 38 | 313 |
| Family Medicine | 65 | 32 | 9 | 106 |
| Medical Genetics | 5 | – | – | 5 |
| Neurology | 110 | 20 | 29 | 159 |
| Oncology | 103 | 9 | 23 | 135 |
| Pediatrics | 92 | – | – | 92 |
| Physical Medicine and Rehab. | 51 | 4 | 6 | 61 |
| Psychiatry and Psychology | 87 | 15 | 10 | 112 |
| Sub-Total | 778 | 131 | 122 | 1,031 |

* Mayo Clinic Jacksonville Hematology includes Oncology and Hypertension includes Nephrology.

| Department/Division | Rochester | Florida | Arizona | Total |
|---|---|---|---|---|
| Surgery | | | | |
| General Surgery | 36 | 6 | 7 | 49 |
| Plastic Surgery | 12 | 4 | 4 | 20 |
| Pediatric Surgery | 5 | – | – | 5 |
| Colon and Rectal Surgery | 10 | 3 | 2 | 15 |
| Thoracic and Cardiovascular | 22 | 6 | 3 | 31 |
| Transplant Surgery | 8 | 30 | 15 | 53 |
| Vascular Surgery | 6 | 3 | 2 | 11 |
| Research | 6 | – | – | 6 |
| Sub-Total | 105 | 52 | 33 | 190 |
| Surgical Specialties | | | | |
| Anesthesiology | 147 | 32 | 24 | 203 |
| Dentistry | 8 | – | – | 8 |
| Neurologic Surgery | 23 | 10 | 5 | 38 |
| Obstetrics and Gynecology | 45 | 5 | 5 | 55 |
| Ophthalmology | 40 | 10 | 6 | 56 |
| Orthopedics | 66 | 13 | 10 | 89 |
| Otorhinolaryngology | 28 | 9 | 10 | 47 |
| Urology | 24 | 7 | 7 | 38 |
| Audiology and Critical Care | – | 11 | 6 | 17 |
| Sub-Total | 381 | 97 | 73 | 551 |
| Clinical & Research Laboratories | | | | |
| Biochemistry | 23 | – | – | 23 |
| Immunology | 10 | – | – | 10 |
| Pathology | 156 | 19 | 22 | 197 |
| Pharmacology | 9 | – | – | 9 |
| Physiology | 21 | – | – | 21 |
| Research and Other | 106 | 49 | 38 | 193 |
| Sub-Total | 325 | 68 | 60 | 453 |
| TOTAL | 2,361 | 497 | 456 | 3,314 |

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The following table summarizes measures of service for Mayo Clinic's clinical practice for the three years ended December 31, 2013, 2014 and 2015. The measures of clinical service include the affiliated regional practices of the Mayo Clinic Health System, except for Core Procedures which are surgical, anesthesia, radiology, diagnostic and therapeutic procedures so categorized by the American Medical Association, and include procedures such as cardiac catheterization, echocardiograms, ablation procedures, endoscopic procedures, dialysis and gastrointestinal procedures.

**Measures of Clinical Service**

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2013 | 2014 | 2015 |
| Outpatient Visits | 4,946,293 | 4,784,301 | 4,804,134 |
| Surgical Patients | 128,693 | 127,457 | 132,420 |
| Core Procedures* | 3,833,143 | 3,828,848 | 3,815,122 |

*Does not include Mayo Health System

The following table summarizes the gross payor mix for Mayo Clinic Hospital-Rochester, Mayo Clinic Florida and Mayo Clinic Arizona for the three years ended December 31, 2015.

**Payor Mix**
**Percentage of Gross Revenue**
**Rochester, Florida, Arizona**

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2013 | 2014 | 2015 |
| Medicare | 41.9% | 41.8% | 43.7% |
| Medicaid | 5.6 | 6.2 | 6.9 |
| Contract | 38.7 | 38.4 | 38.4 |
| Employee | 5.7 | 5.7 | 5.5 |
| Other/Self Pay | 8.1 | 7.9 | 5.5 |
| Total | 100.0% | 100.0% | 100.0% |

Patients come to Mayo from all over the world. However, at each of the three Mayo Clinic locations, the highest percentage of patients registering come from that Clinic's home state and region. For 2015 in Rochester, approximately 64% of patients came from the state of Minnesota and an additional 27% came from states in the upper Midwest. In Florida, approximately 82% of the patients registering in 2015 came from Florida and an additional 12.5% from other states in the Southeast. In Arizona, approximately 78% of patients registering in 2015 came from Arizona and an additional 8% came from neighboring Southwest states. While Mayo currently does not operate any health care facilities overseas, it maintains small offices overseas to help assist patients interested in receiving medical services at a Mayo Clinic facility. Mayo Clinic continues to explore ways to provide opportunities for people from all over the world to receive healthcare services from Mayo physicians. The tables below summarize patient origin at all three Mayo Clinic locations.

**Mayo Clinic Patient Origin**
**2013-2015**

**Rochester**

| | 2013 | 2014 | 2015 |
|---|---|---|---|
| Minnesota | 64.2% | 64.5% | 64.2% |
| Iowa | 8.4 | 8.6 | 8.6 |
| Wisconsin | 6.2 | 6.1 | 6.1 |
| Illinois | 4.0 | 3.9 | 3.8 |
| North Dakota | 2.0 | 1.9 | 2.0 |
| Michigan | 1.8 | 1.7 | 1.8 |
| South Dakota | 1.5 | 1.5 | 1.5 |
| Missouri | 0.9 | 0.9 | 0.9 |
| Indiana | 0.9 | 0.8 | 0.8 |
| Nebraska | 0.7 | 0.6 | 0.6 |
| Subtotal | 90.6% | 90.5% | 90.3% |
| | | | |
| Other U.S. | 8.1 | 8.0 | 8.2 |
| Canada | 0.3 | 1.2 | 1.2 |
| Other Foreign | 1.0 | 0.3 | 0.3 |
| Total | 100.0% | 100.0% | 100.0% |

**Florida**

| | 2013 | 2014 | 2015 |
|---|---|---|---|
| Florida | 80.2% | 81.1% | 82.0% |
| Georgia | 9.3 | 9.1 | 8.9 |
| Alabama | 1.0 | 0.9 | 0.9 |
| North Carolina | 0.7 | 0.6 | 0.6 |
| South Carolina | 1.8 | 1.6 | 1.5 |
| Tennessee | 0.7 | 0.7 | 0.6 |
| Subtotal | 93.7% | 94.0% | 94.5% |
| | | | |
| Other U.S. | 5.5 | 5.1 | 4.7 |
| Foreign | 0.8 | 0.9 | 0.8 |
| Total | 100.0% | 100.0% | 100.0% |

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**Arizona**

| | 2013 | 2014 | 2015 |
|---|---|---|---|
| Arizona | 77.7% | 77.8% | 77.9% |
| California | 2.2 | 2.3 | 2.3 |
| Colorado | 1.4 | 1.4 | 1.4 |
| New Mexico | 2.8 | 2.8 | 2.8 |
| Nevada | 1.5 | 1.5 | 1.5 |
| Utah | 0.3 | 0.3 | 0.3 |
| Subtotal | 85.9% | 86.1% | 86.2% |
| | | | |
| Other U.S. | 12.6 | 12.7 | 12.8 |
| Foreign | 1.5 | 1.2 | 1.0 |
| Total | 100.0% | 100.0% | 100.0% |

**Mayo Clinic Health System**

Since 1992, Mayo Clinic has developed a regional affiliate network of physician clinics and local community hospitals in southern Minnesota, northern Iowa and western Wisconsin. Through this network, Mayo Clinic expects to preserve patient choice within the region and maintain its overall market position. Mayo Clinic Health System currently consists of 10 nonprofit clinic groups, staffed predominantly with primary care physicians, shown in the table below. Collectively, this network of clinics (and the 18 affiliated nonprofit hospitals described below under "– Mayo Clinic Health System Hospitals") is known as Mayo Clinic Health System and employs approximately 950 full-time equivalent physicians as of December 31, 2015. Mayo Clinic may add more clinics and hospitals to the Mayo Clinic Health System in the future as part of its regional strategy to develop an integrated, geographically distributed provider network.

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**Mayo Clinic Health System**
**Regional Practice Physician Summary**
**As of December 31, 2015**

| | Primary Location | Physicians |
|---|---|---|
| Mayo Clinic Health System - Eau Claire | Eau Claire, WI | 245 |
| Mayo Clinic Health System - Albert Lea and Austin | Albert Lea, MN | 166 |
| Mayo Clinic Health System - Cannon Falls | Cannon Falls, MN | 4 |
| Mayo Clinic Health System - Red Cedar | Menomonie, WI | 39 |
| Mayo Clinic Health System - Franciscan Medical Center | La Crosse, WI | 209 |
| Mayo Clinic Health System - Lake City | Lake City, MN | 10 |
| Mayo Clinic Health System - Decorah Clinic Physicians | Decorah, IA | 22 |
| Mayo Clinic Health System – Owatonna | Owatonna, MN | 40 |
| Mayo Clinic Health System - Mankato | Mankato, MN | 186 |
| Mayo Clinic Health System - Red Wing | Red Wing, MN | 29 |
| Total Physicians | | 950 |

*Mayo Clinic Affiliated Hospitals*

Following the integration of the Mayo Clinic-Saint Marys Hospital and Mayo Clinic-Methodist Hospital with Mayo Clinic in 1986, Mayo Clinic assumed management of the two hospitals with a view towards reducing duplication of patient care services, consolidating administration and support services, and achieving economies of scale. Management of both hospitals is now consolidated with Mayo Clinic as part of an integrated practice model. Mayo Clinic-Saint Marys Hospital changed its name to Mayo Clinic Hospital-Rochester on September 1, 2013. As of January 1, 2014, Mayo Clinic Hospital-Rochester and Mayo Clinic-Methodist Hospital merged, and Mayo Clinic Hospital-Rochester was the surviving entity.

Mayo Clinic Hospital-Rochester is a tertiary care facility located in Rochester, Minnesota with a combined 2,059 licensed beds, 1,263 of which are staffed, and 116 surgical suites as of December 31, 2015. Mayo Clinic physicians practicing in Rochester, Minnesota admit all patients requiring hospitalization to Mayo Clinic Hospital-Rochester, and Mayo Clinic physicians in Rochester comprise the entire medical staff of Mayo Clinic Hospital Rochester.

Mayo Clinic Hospital-Rochester Saint Marys campus is located on a 44-acre site one-half mile west of the Mayo Medical Center campus. Some of the state of the art services provided at Saint Marys campus include computer-assisted laser neurosurgery, cardiac and lung transplantation, and a stroke and epilepsy unit. Saint Marys campus has a Level One Trauma Center, providing emergency services for the southeastern Minnesota region. The Generose building, located on the southwest corner of the Saint Marys campus, is Mayo Clinic's specially designed psychiatric inpatient facility in Rochester which contains 108 licensed beds, 73 of which are staffed. Physicians in Mayo Clinic Departments of Orthopedic Surgery, Obstetrics and Gynecology, and Community Medicine admit the majority of their patients requiring hospitalization to Mayo Clinic Hospital-Rochester Methodist campus. Mayo Clinic liver, pancreas, and bone marrow transplant programs are also based at the Methodist campus.

Mayo Clinic Florida operates a 304 bed and 24 surgical suite teaching and research hospital on Mayo Clinic Jacksonville's campus staffed exclusively by Mayo physicians. At Mayo Clinic Florida, 249 beds are currently staffed. MCHSW, a controlled affiliate of Mayo Clinic Jacksonville, operates a 231 licensed bed acute care hospital, with 189 beds available as of December 31, 2015, as well as a skilled nursing facility and related facilities located in Waycross, Georgia.

In November 2015, the Trustees of Mayo Clinic approved returning the hospital, nursing facility and other facilities at MCHSW, together with its related governance, to the local control by an unaffiliated board of directors, and to winding up the integration agreement between Mayo Clinic Jacksonville and Satilla Health Services (the locally controlled nonprofit corporation), that led to the establishment of MCHSW. Negotiations to formalize the dis-affiliation are currently under way. It is not possible at this point to determine when those negotiations will be concluded, what form any dis-affiliation will take, and what long term and short term financial impact, if any a dis-affiliation on similar arrangement will have on the financial conditions or operations of Mayo Clinic.

Mayo Clinic Hospital, a division of Mayo Clinic Arizona located in Phoenix, Arizona, is a 268 bed acute care hospital containing 261 medical and surgical beds, 24 operating rooms for inpatient and outpatient surgery, a rehabilitation unit containing seven beds and related facilities. All of the licensed beds at Mayo Clinic Hospital currently are staffed. It provides a full range of medical and surgical services, including solid organ and bone marrow transplantation, to meet the demands of Mayo Clinic Arizona's multispecialty group practice. Mayo Clinic Arizona physicians comprise the entire medical staff of Mayo Clinic Hospital and admit virtually all their patients that require hospitalization to Mayo Clinic Hospital.

Mayo Clinic Health System Hospitals. The following table lists the regional practice hospitals that have become affiliated with Mayo Clinic since 1992. In most cases, these hospitals became affiliated with Mayo following its acquisition of a local clinic or provider group. The regional hospitals provide mostly primary and secondary care services. Many patients requiring specialized, acute care treatment are referred to the Rochester hospitals.

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**Mayo Clinic Health System Hospital Summary**
**As of December 31, 2015**

| | Location | Affiliated Clinic | Licensed Bed Capacity | Staffed Beds |
|---|---|---|---|---|
| Mayo Clinic Health System – Albert Lea and Austin | Austin, MN and Albert Lea, MN | Austin and Albert Lea | 159 | 67 |
| Mayo Clinic Health System - Cannon Falls | Cannon Falls, MN | Cannon Falls | 15 | 15 |
| Mayo Clinic Health System - Eau Claire Hospital[1] | Eau Claire, WI | Eau Claire | 372 | 234 |
| Mayo Clinic Health System - Franciscan Medical Center[2] | LaCrosse, WI | La Crosse | 356 | 150 |
| Mayo Clinic Health System – Mankato[3] | Mankato, MN | — | 462 | 219 |
| Mayo Clinic Health System - Red Cedar | Menomonie, WI | Red Cedar | 25 | 23 |
| Mayo Clinic Health System - Lake City | Lake City, MN | Lake City | 18 | 11 |
| Mayo Clinic Health System - Red Wing | Red Wing, MN | Red Wing | 50 | 22 |
| Total Beds | | | 1,457 | 741 |

[1] Also includes Mayo Clinic Health System—Northland in Barron, WI; Mayo Clinic Health System—Chippewa Valley in Bloomer, WI; Mayo Clinic Health System – Oakridge in Osseo, WI.

[2] Also includes Mayo Clinic Health System - Sparta in Sparta, WI.

[3] Also includes Mayo Clinic Health System - Fairmont in Fairmont, MN; Mayo Clinic Health System - New Prague in New Prague, MN; Mayo Clinic Health System - Springfield in Springfield, MN; Mayo Clinic Health System - St. James in St. James, MN; and Mayo Clinic Health System - Waseca in Waseca, MN

The following table sets out certain measures of service at Mayo Clinic hospitals for the three years ended December 31, 2015.

**Measures of Hospital Service**
**Rochester, Florida, Arizona, Mayo Clinic Health System Hospitals**

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2013 | 2014 | 2015 |
| Admissions | 130,503 | 128,596 | 127,935 |
| Patient Days | 603,757 | 624,937 | 640,879 |
| Average Length of Stay | 4.6 | 4.9 | 5.0 |

*Educational Activities*

Mayo Clinic's educational activities are conducted by the College of Medicine, a division of Mayo Clinic that includes Mayo Graduate School, Mayo School of Graduate Medical Education, Mayo Medical School, Mayo School of Health Sciences and Mayo School of Continuous Professional Development. In 2015, Mayo Clinic's commitment to education, including stipends for medical residents and trainees, totaled $283.6 million, with Mayo Clinic funds and gifts to Mayo Clinic accounting for $224.7 million, or 79.2%, of this amount.

Mayo Graduate School was established in 1989 and has a current enrollment of approximately 290 Ph.D. and M.S. students. It offers advanced training for students interested in research careers and grants the Ph.D. degree in biomedical sciences in seven areas of specialization. Mayo Graduate School also grants

the M.S. degree in biomedical sciences to physicians and dentists in several clinical residency training programs, and to Mayo research fellows and allied health staff.

Mayo School of Graduate Medical Education, established in 1915, sponsors the largest number of ACGME-accredited programs for graduate medical education in the nation, with approximately 2,211 physicians (which includes approximately 586 physicians with research appointments) in training. The faculty is composed of Mayo Clinic staff members in clinical (patient care) medicine and the basic medical sciences. Residency training in internal medicine, surgery, or the medical and laboratory specialties generally requires three years or longer. During their training, physicians may earn advanced academic degrees conferred by Mayo Graduate School. Mayo Clinic provides most of the funds for its residency programs, with additional support from governmental sources. More than 20,000 alumni of the Mayo School of Graduate Medical Education engage in medical practice, teaching, and research throughout the United States and 75 foreign countries. Most physicians enrolled in clinical residency or fellowship training are based in Rochester (1,234 trainees), but educational programs also take place at Mayo Clinic in Florida (205 trainees) and Mayo Clinic in Arizona (186 trainees).

Mayo Medical School opened in 1972. Its faculty consists of physicians and scientists from Mayo Clinic campuses in Minnesota, Florida and Arizona as well as from Mayo Clinic Health System. Current enrollment in the four year program leading to the M.D. degree is 216. Six of the students who have matriculated to the Medical School this academic year enrolled through the Medical Scientist Training Program (MSTP), a program jointly administered with Mayo Graduate School, through which student will graduate with both M.D. and Ph.D. degrees. Two students were enrolled through Mayo Clinic's Oral and Maxillofacial Surgery Residency program. Mayo Medical School received 4,347 applications for the 2015-2016 academic year for the M.D.-only program. In addition to the four year curriculum, a visiting student clerkship program affords intensive short-term training each year for over 580 students visiting from other medical schools throughout the world.

Mayo School of Health Sciences (MSHS) offers more than 100 allied health education programs ranging from certificate to post-doctoral levels and covering more than 50 unique healthcare professions, with approximately 1,668 students enrolled during 2015. The larger programs offered include post-graduate programs in pharmacy, graduate programs in physical therapy and nurse anesthesia; a post baccalaureate program in surgical first assisting; undergraduate programs in radiography, sonography, medical lab science, phlebotomy, and respiratory care; and clinical rotations for students in social work, physician assistant, nurse practitioner, and occupational therapy programs. Many MSHS programs are offered in collaboration with other accredited higher education providers. Graduating students provide a steady stream of well-qualified employees for Mayo Clinic's workforce needs at the three Mayo Clinic practice sites.

Mayo School of Continuous Professional Development (MSCPD) has been involved in continuing medical education since the Mayo brothers' involvement in the Southern Minnesota Medical Association in the early 1890s. This history of active participation in education has expanded to include creating opportunities for other U.S. and international physicians to visit Mayo to observe and learn new techniques. This year, MSCPD will educate nearly 130,000 physicians and other health care professionals through the school's continuing medical education courses, conferences and other distance learning activities. MSCPD is also engaged in supporting physicians for their maintenance of certification ("MOC") requirements and in ensuring that competency-based education leads to competency-based behavior, with just over 1,450 participants on MOC approved projects through its program.

*Research Activities*

Research has been an integral component of Mayo Clinic's activities since its formation in the early 1900s. Today, approximately 1,041 members of Mayo's consulting staff in Rochester, Jacksonville and Arizona are involved in some form of research on either a full or part-time basis. Mayo Clinic expenditures for research totaled $659 million in 2015, with $382 million, or 58.0%, of those funds coming from outside sources and $277 million, or 42.0%, coming from gifts or from Mayo Clinic itself.

Mayo Clinic's research activities range from projects carried out by a single scientist to interdisciplinary programs through which investigators representing a number of fields join forces to attack diseases. One such program is the Mayo Comprehensive Cancer Center, part of a nationwide system established by the National Cancer Institute to further prevention, diagnosis and treatment of cancer. Other interdisciplinary ventures include structured activities in genomics/proteomics/bioinformatics, molecular medicine, transplantation biology including xenographic transplantations and the investigation of diseases of the nervous, cardiovascular and immune systems. In these programs, research scientists, clinical physicians and clinical investigators cooperate to investigate diseases. Mayo Clinic believes that laboratory research experiences form an essential part of a physician's training and are necessary to maintain an intellectually progressive staff. In 2015, 409 research physician and scientist full-time equivalents ("FTEs") were involved in research activities.

Mayo Clinic Jacksonville and Mayo Clinic Arizona continue to develop their research activities through personnel and facilities growth. In 2015, 44 research consultant FTEs conducted research at Mayo Clinic Jacksonville, focusing primarily on Alzheimer's research, other areas of the neurosciences and cancer-related research. At Mayo Clinic Arizona, 32 research consultant FTEs were dedicated to the investigation of molecular and cellular biology, and cancer-related research is underway. Both clinics have buildings devoted exclusively to research.

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**Mayo Clinic**
**Summary of Consolidated Statements of Activities**
**(In Millions of Dollars)**

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2013 | 2014 | 2015 |
| Revenue, gains, and other support: | | | |
| Net medical service revenue | $7,902 | $8,165 | $8,620 |
| Grants and contracts | 372 | 375 | 386 |
| Investment return allocated to current activities* | 170 | 173 | 233 |
| Contributions available for current activities* | 232 | 179 | 211 |
| Premium revenue | 115 | 132 | 144 |
| Other | 630 | 737 | 721 |
| Total revenue, gains, and other support | 9,421 | 9,761 | 10,315 |
| Expenses: | | | |
| Salaries and benefits | 5,930 | 5,872 | 6,371 |
| Supplies and services | 2,139 | 2,290 | 2,621 |
| Facilities | 650 | 669 | 697 |
| Finance and investment | 90 | 96 | 100 |
| Total expenses | 8,809 | 8,927 | 9,789 |
| Income from current activities | 612 | 834 | 526 |
| Non-current and other items: | | | |
| Contributions not available for current activities, net* | 153 | 98 | 60 |
| Unallocated investment return, net* | 433 | 230 | (111) |
| Income tax expense | (22) | (32) | (33) |
| Other | 9 | (2) | 1 |
| Total non-current and other items | 573 | 294 | (83) |
| Increase (decrease) in net assets before other changes in net assets | 1,185 | 1,128 | 443 |
| Pension and other post-retirement benefit adjustments | 1,782 | (1,590) | 12 |
| Increase (decrease) in net assets | 2,967 | (462) | 455 |
| Net assets at beginning of period | 4,687 | 7,654 | 7,192 |
| Net assets at end of period | 7,654 | 7,192 | 7,647 |

* Restricted activity of $545 million, $365 million and $260 million for the years 2013, 2014 and 2015, respectively, is included in "Investment return allocated to current activities," "Contributions available for current activities," "Contributions not available for current activities, net" and "Unallocated investment return, net." Assets released from restriction were $166 million, $180 million and $206 million for the years 2013, 2014 and 2015, respectively.

**Management's Discussion**

*Review of 2013-2015 Financial Results*

Mayo Clinic's consolidated revenue, gains and other support for 2015 was $10.3 billion, an increase of 5.7% from $9.8 billion in 2014 and 9.5% from $9.4 billion in 2013. Net medical service revenue generated from patient care activities, which comprised 83.6% of total revenue, gains and other support in 2015, was $8.6 billion, an increase of 5.6% from $8.2 billion in 2014 and 9.1% from $7.9 billion in 2013. Revenue, gains and other support from grants, contracts, allocated investment income, premium revenue, business extensions, contributions available for current activities and other non-medical services was $1.7 billion in 2015 (16.4% of total revenue, gains and other support), an increase of 6.2% from $1.6 billion in 2014 and an increase of 11.6% from $1.5 billion in 2013.

Mayo Clinic's consolidated expenses were $9.8 billion in 2015, an increase of 9.7% from $8.9 billion in 2014 and an increase of 11.1% from $8.8 billion in 2013. Salaries, benefits, supplies and services totaled $9.0 billion, an increase of 10.2% from 2014 and 11.4% from 2013 and accounted for 91.9% of consolidated expenses in 2015. These expenses are principally related to the volumes and acuity of patients seen at Mayo Clinic. Patient care expense was $7.3 billion in 2015, an increase of 8.7% from $6.8 billion in 2014 and an increase of 7.7% from $6.8 billion in 2013. Depreciation and amortization, both of which are non-cash items, totaled $455 million in 2015, $437 million in 2014, and $423 million in 2013. Interest expense totaled $79 million in 2015, $80 million in 2014, and $80 million in 2013.

Income from current activities ("ICA"), which Mayo Clinic considers to be the best indicator of the financial performance of its continuing operations, was $526 million for 2015, a decrease from $834 million in 2014 and $612 million in 2013. The decrease was partially attributable to increases in pension expenses of $192 million due to a decrease in discount rate that was effective as of December 31, 2014 and a change to the new actuarial mortality tables. These amounts, when calculated as a percentage of total revenue, gains and other support, translate into ICA margins of 5.1% for 2015, 8.5% for 2014, and 6.5% for 2013.

Mayo Clinic records gains and losses from non-operational activities as "non-current and other items" on its consolidated statements of activities. In the years 2013, 2014 and 2015, these items resulted in a net gain(loss) of $573 million, $294 million and ($83) million, respectively. The decrease in 2015 is mostly attributable to the lower investment returns for 2015 compared to those for 2014 and 2013. Development contributions not available to support current activities and investment returns over and above the amount recorded in revenue, gains and other support are the most significant components of Mayo Clinic's net gains(losses) from non-current and other items.

Mayo Clinic's net assets increased by $2,967 million from January 1, 2013 to December 31, 2013; decreased by $462 million from January 1, 2014 to December 31, 2014; and increased by $455 million from January 1, 2015 to December 31, 2015. The decrease in 2014 was mainly due to pension and other post-retirement benefit adjustments, a non-cash expense, of negative ($1,590) million.

The pension and other post-retirement benefit adjustments are based on a number of factors, including changes in the discount rate used to determine the projected benefit obligations and actual annual rate of return compared to the assumed annual rates of return on assets invested in pension funds. From 2012 to 2014, the discount rate used to determine the projected benefit obligation fluctuated from 4.27% per annum to 5.17% per annum to 4.28% per annum. The lowering of the discount rate was a major contributing factor to the unfavorable pension and other post-retirement contributions adjustment to expense in 2014. In 2015 the applicable discount rate increased to 4.70%. This, along with contributions and investment returns, resulted in the estimated benefit obligations of the qualified Pension Plans

exceeding the fair value of plan assets by $519 million at December 31, 2015, a decrease from $797 million as of December 31, 2014.

Mayo Clinic's net assets increased from $4.7 billion on January 1, 2013 to $7.6 billion on December 31, 2015, a cumulative increase of $2,961 million, or 63.2%, over the three year period.

*Review of 2013-2015 Practice Operations*

Over the three year period ended December 31, 2015, annual patient volumes at Mayo Clinic, as measured by outpatient visits, have decreased from 4,946,293 in 2013 to 4,804,134 in 2015, and surgical patients have increased from 128,665 in 2013 to 132,420 in 2015. Core procedures at the Rochester, Florida and Arizona sites have remained approximately the same at 3,833,143 in 2013 to 3,815,122 in 2015. At Mayo Clinic's hospitals (including those in the Mayo Clinic Health System), patient days increased from 603,757 in 2013 to 640,879 in 2015; and admissions decreased from 130,503 to 127,935 over the same period.

Mayo Clinic continues to provide suitable levels of care in appropriate settings delivered by appropriate providers, which involves (among other things) moving some patients into an outpatient setting while treating others with acute needs in an inpatient hospital setting. Mayo believes that this approach best serves each patient's needs and is consistent with efforts to effectively control the cost of quality health care delivery. To that end, the Medicare case mix at Mayo's large hospitals reflect higher acuity levels in patients: at Mayo Clinic Hospital – Rochester, the Medicare case mix was 2.27 in 2015, up from 2.21 in 2014; at Mayo Clinic Florida's hospital, the Medicare case mix was 2.14 in 2015, up from 2.10 in 2014; and at Mayo Clinic Hospital in Phoenix, Arizona, the Medicare case mix was 2.15 in 2015, up from 2.09 in 2014.

*Outlook for Practice Operations*

Mayo Clinic continues to make the necessary investments to maintain its leadership in the delivery of care, provide solutions and hope for its patients, set the benchmark for delivering an unparalleled patient experience, and extend Mayo's knowledge and services to much broader populations. Examples include:

- Center for the Science of Health Care Delivery. Create, evaluate and implement practices and policies that will lead to more accessible, affordable, high value patient-centric care delivery. Through Mayo Clinic's collaboration with Optum Labs and others, the Center for the Science of Health Care Delivery is working on program and analytics that will position Mayo Clinic for bundled payment, value based purchasing, and population health management.

- Center for Individualized Medicine. Apply knowledge gained from Mayo's discovery and translational activities in pharmacogenomics, epigenetics, microbiome, patient genomics and biomarker development to serve Mayo Clinic's current and future patients and partner with them to achieve better health in a personalized and economically viable manner.

- Center for Regenerative Medicine. Further the discovery, translation, and application of knowledge in the science and practice of regenerative medicine, which focuses on functional restoration of damaged tissue. This has the potential to add significant value and reduce health care costs over time, promising a new generation of health care solutions.

- Outpatient Practice Innovation. The Clinical Practice Committee has partnered with the Center for Innovation to reimagine the outpatient practice of the future. The goal is to

substantially reduce outpatient practice costs while maintaining or improving patient experience and quality of care.

- Ask Mayo Expert. A computer application for providing physicians and other providers organized Mayo Clinic medical knowledge making it universally accessible, useful, and actionable in an accelerated delivery model.

- Mayo Clinic Care Network. Make available Mayo Clinic knowledge and expertise to member hospitals and health systems to improve the care of patients within the communities where they seek care. To date, Mayo Clinic has made arrangements to share its knowledge and expertise, including providing access to Mayo's eConsults and other eHealth services, with 37 regional health systems that currently are members of the Mayo Clinic Care Network.

- Connected Care. Connected Care services provide timely access to Mayo Clinic specialty opinions. These services are designed to be convenient for patients, allowing them to avoid travel to other sites, hotels, meals, logistics and parking concerns, work-life scheduling, and other costs associated with scheduling care at a remote location.

- Competitive Market Plan. An integrated framework and focused strategic investment in select high performing demand generation tactics. This includes patient care priorities, process and redesign, augmented with capacity build out investments for strategic clinical growth and acceleration of translation of transformative center and research initiatives into clinical practice.

*Research and Education Funding*

Medical research and education are essential components of Mayo Clinic's mission. Overall funding for research and education has grown from $912 million in 2013 to $945 million in 2015. In 2015, Mayo Clinic's commitment to education, including stipends for medical residents and trainees, totaled $286 million, with Mayo Clinic funds accounting for $225 million, or 78.6%, of this amount. In 2015, Mayo Clinic expenditures for research totaled $659 million, with $281 million, or 42.6%, provided by gifts or from Mayo Clinic funds. Government, foundations and industry sources helped fund a large portion of these important activities along with Mayo Clinic funds, mostly from endowment earnings and benefactor gifts. Mayo Clinic funding for research and education over the 2013 to 2015 period averaged $496 million per year. Mayo Clinic continues to pursue innovative partnerships with academic institutions, philanthropists, government and industry to further its research and education efforts.

*Development Program*

Mayo Clinic's development program continues to serve as an important source of support for Mayo Clinic's programs and activities. In 2015, Mayo Clinic received contributions totaling $271 million including changes in pledges, gains/losses on internal and externally managed trusts. Contributions available for current activities totaled $211 million. Gifts not available for current activities (such as contributions for endowment or for capital), net of gains/losses and expenses, totaled $60 million. Over the past three years, total contributions, net of changes in pledges, gains/losses on internal and externally managed trusts and expenses, were $932 million or an average of $311 million annually.

*Investment Program*

Mayo Clinic has had an active investment program for many years, using investment returns to support Mayo Clinic programs and activities. As of December 31, 2015, the market value of Mayo Clinic's cash

and investments was $7.2 billion. Of this total, approximately $5.7 billion was invested in the Long Term Fund, Mayo's primary commingled investment pool. The Long Term Fund, which is comprised of a mix of donor-restricted and board-designated endowment funds as well as various long-term reserves, follows a total return investment strategy with the objective of generating a "real" (inflation-adjusted) return of at least five percent per annum over a market cycle. By policy, approximately 85% of Long Term Fund assets are invested in equities and equity-related "alternative investment" strategies such as absolute return, private equity, and real asset funds. The approximately 15% remaining of the Long Term Fund assets are invested in bonds and/or cash. Approximately 54% of the Long Term Fund assets were invested in "alternative investments" as of December 31, 2015 and, based on outstanding partnership commitments, an additional $1.0 billion is expected to be drawn down and invested over the next three to five years in these alternative investment partnerships. In 2015, these partnerships drew $315 million from and distributed $245 million to Mayo Clinic. For the year ended December 31, 2015, the Long Term Fund had a return of 1.5% and had annualized investment returns of 8.5%, 8.6% and 7.8% for the trailing three-year, five-year and ten-year periods, respectively.

Mayo Clinic also maintains a second investment pool called the Short Term Fund that serves as a liquidity reserve on which it can draw for unforeseen needs. It follows a stable fixed income strategy and is invested solely in high quality, short-duration bonds. As of December 31, 2015 the Short Term Fund had a fair market value of $670 million. For the year ended December 31, 2015, the Short Term Fund earned a 0.6% return and had an annualized investment return of 0.7% for the trailing three-year period and 1.8% for the trailing five-year period.

As of December 31, 2015, Mayo Clinic's investments, other than the Short Term and Long Term Funds, consisted of $96 million in working capital and $768 million of segregated reserves, the largest components of which are deferred compensation assets of $421 million and Mayo Insurance Company Limited, with assets of $123 million.

Mayo Clinic allocates an amount equal to approximately five percent of the fair market value of its endowment-related investments (currently based on the 36-month moving average as of September 30 of the preceding fiscal year) for support of programs and activities each year. This amount, plus an amount determined with reference to current year interest expense on certain Mayo Clinic debt, is reported as "investment return allocated to current activities" in the revenue, gains and other support section of its Consolidated Statements of Activities. The balance between Mayo Clinic's total investment return and the amount allocated to current activities is reported as "unallocated investment return, net" in the non-current and other items section of Mayo Clinic's Consolidated Statements of Activities. Given Mayo Clinic's long-term investment objectives and its policy for reporting investment earnings as described above, "unallocated investment return, net" is subject to significant year-to-year fluctuations. The portion of Mayo Clinic's investment return allocated to the revenue, gains and other support section of Mayo Clinic's Consolidated Statements of Activities was $170 million in 2013, $173 million in 2014 and $233 million in 2015, and the portion allocated to the non-current and other portions section of Mayo Clinic's Consolidated Statements of Activities was $433 million in 2013, $230 million in 2014 and ($111) million in 2015.

Mayo Clinic's Treasury Services staff manages Mayo Clinic's investment funds in consultation with a variety of external professional investment managers. Mayo Clinic's Investment Committee, which is a standing committee of Mayo Clinic's Board of Trustees, approves all investment policies and provides oversight of investment operations and performance.

*Pension Fund*

Mayo Clinic has a number of non-contributory defined benefit pension plans covering most employees. The plan that covers most non-union employees (the "Mayo Pension Plan") previously provided pension

benefits based on years of service and the employee's highest compensation during three of his or her last ten consecutive years of employment. In 2009, Mayo Clinic announced changes to the Mayo Pension Plan. Effective January 1, 2015, the normal retirement benefit changed from a final average pay formula to a career pay formula. Benefit accruals through December 31, 2014 continued to be determined under the final average pay formula and were frozen as of that date, and benefit accruals beginning January 1, 2015 are determined under the career pay formula. Plans covering union members ("Union Plans" and, together with Mayo Pension Plan, the "Pension Plans" or "Plans") generally provide benefits of stated amounts for each year of service.

As of December 31, 2015, the present value of the qualified projected pension benefits exceeded the fair value of the pension trusts assets by $519 million. Mayo Clinic contributed $505 million to qualified pension trusts between January 1, 2015 and December 31, 2015, as compared to contributions to the qualified pension trusts of $410 million for pension year ending 2014 and $260 million for pension year ending 2013. Mayo Clinic anticipates making contributions to the qualified pension trusts in the future depending on the funded status of the plan. Over the 2016 to 2020 periods, the combined service cost for the Pension Plans is expected to be between $350 and $375 million annually. The costs of pensions, including service costs, interest costs, and amortization of actuarial gains and losses, are reported as an operating expense on Mayo Clinic's Consolidated Statements of Activities. Market interest rates and debt and equity market fluctuations could potentially have an impact on Mayo Clinic's pension fund liabilities and its requirements for funding its related pension expenses.

Mayo Clinic also sponsors various defined contribution plans in which substantially all of its employees are eligible to participate. Beginning January 1, 2015, Mayo Clinic matched employee contributions up to 4% of their salary based on their years of service. Mayo Clinic contributed approximately $80 million to these plans in 2015.

*Post-Retirement Healthcare Benefits*

Mayo Clinic sponsors post-retirement benefit plans that cover both salaried and non-salaried employees whose employment began prior to January 1, 2002. The plans currently provide medical, dental and life insurance and are contributory for retirees below age 65 and non-contributory for retirees age 65 and older. The post-retirement plan projected benefit obligation was $768 million, $843 million and $841 million at the end of the calendar year for 2013, 2014 and 2015, respectively. The post-retirement plans are unfunded. Were Mayo Clinic to reduce the benefits currently provided in its post-retirement benefit plans or use less conservative assumptions than those currently used to estimate the cost of future post-retirement benefits, there would be a significant reduction in the size of its accrued post-retirement benefits costs.

In 2013, 2014 and 2015, Mayo Clinic recognized $69 million, ($6) million and ($4) million in income, respectively as an expense for post-retirement benefits under "Salaries and benefits" in Mayo Clinic's Consolidated Statements of Activities. The actual current service cost of post-retirement benefits was $31 million in 2013, $11 million in 2014 and $12 million in 2015.

In January 2014, Mayo announced a change in the self-insured post-retirement benefit plans where eligible employees who retire on or after January 1, 2015, will not participate in the Mayo Clinic self-insured group retiree medical benefits program. Instead, Mayo Clinic will provide an employer subsidy through contributions to a Health Reimbursement Account (HRA) that the participant can use to purchase individual medical and/or prescription drug coverage. The effects of this plan amendment were reflected in the benefit obligation, as shown above.

These changes are expected to continue to lower Mayo Clinic's post-retirement healthcare benefit costs and slow the growth of the balance sheet liability.

*Strategic Capital Investments*

In 2013, 2014 and 2015, Mayo Clinic spent $628 million, $516 million and $628 million on purchases of property, plant and equipment in Rochester, Florida, Arizona and Mayo Clinic Health System, underscoring its commitment to make the capital investments that it believes are necessary to sustain and enhance its practice, research and education activities. These capital expenditures include the costs of the Proton Beam Therapy Program in Rochester and Phoenix, bed tower and new surgical suites at the Saint Marys Hospital campus at Mayo Clinic Hospital – Rochester in Rochester, expansion of the hospital facilities in the Mayo Clinic Health System and Florida, information technology, infrastructure upgrades, and electronic health record and revenue cycle management systems. The proton beam therapy program in Rochester opened in June, 2015, and a proton beam therapy program in Phoenix is currently expected to open mid-March, 2016. Mayo Clinic's Board of Trustees approves Mayo Clinic's annual capital budgets and also approves capital expenditures for major new projects. For 2016, Mayo Clinic expects its capital expenditures to total approximately $700 million.

In January 2013, Mayo Clinic announced its Destination Medical Center ("DMC") initiative to secure Mayo Clinic's (and Minnesota's) status as a global medical destination center, now and in the future. The DMC initiative calls for Mayo Clinic to invest approximately $3.5 billion in Mayo-financed capital investments in its Rochester, Minnesota facilities over the next 20 years. That investment, leveraged by private investment currently estimated at approximately $2.8 billion to promote economic development in Rochester and by an additional government investment of approximately $500 million to improve infrastructure, is designed to maintain and enhance Mayo Clinic and Rochester, Minnesota as a global destination for excellence in health care.

Mayo Clinic has an initiative to consolidate onto a single, integrated, patient-centered electronic medical record and revenue cycle management platform. The project is highly complex and integral to operations. Operating and capital expenditures currently are estimated to exceed $1 billion with a project timeline of approximately five years for implementation at all Mayo Clinic locations. Successful installation is expected to enhance Mayo Clinic's ability to further standardize patient care and administrative activities that will improve outcomes and experiences for all patients.

Mayo Clinic expects to fund future capital expenditures from a variety of sources including: (1) cash flow from operations; (2) earnings on Mayo Clinic's investment portfolio; (3) grants and contributions; (4) proceeds of new issuances of bonds and other indebtedness, if determined appropriate by Mayo Clinic; and (5) other available funds.

**Employees**

The following table summarizes the employees of Mayo Clinic. The numbers provided are average full time equivalent positions for 2015.

**Mayo Clinic**
**2015 Average Full Time Equivalent Employees**

| | |
|---|---|
| Staff physicians and medical scientists | 3,901 |
| Allied health | 49,567 |
| Residents, fellows and students | 2,753 |
| Total | 56,221 |

Approximately 1,700 employees are covered by union contracts. The majority of the union employees work at Mayo Clinic Hospital-Rochester. The International Union of Operating Engineers, Local 756, represents employees at the Franklin Heating Station, which provides energy to certain of Mayo Clinic's facilities in Rochester, Minnesota.

Management of Mayo Clinic characterizes relations between itself and its affiliates and their respective employees as good.

**Professional Liability; Litigation and Regulatory Inquiries**

The practice of medicine at all Mayo entities is subjected to peer review to ensure high quality medical and surgical care. Several internal attorneys work with the medical staff, respond to patient complications and complaints, and mitigate the exposure to financial loss.

Mayo Clinic maintains a formal insurance program for the financial risk of professional liability at Mayo's clinical and hospital sites through Mayo Insurance Company Limited, a wholly owned captive insurance company.

The IRS conducted an examination of Mayo Clinic and certain of its affiliates in 2008 through 2010 pursuant to the IRS's Exempt Organizations Team Examination Program. The IRS has challenged Mayo Clinic's treatment of rental income received from certain of its investments, contending that the amounts constitute taxable, unrelated business income. Mayo believes that the income in question is exempt from tax and further believes that it is more likely than not to prevail in this matter, which it expects will take between two to three years to resolve.

Mayo Clinic received an unfavorable outcome, as expected, for the IRS Technical Advice Memorandum and the IRS issued and Mayo has paid a final assessment for the years under audit as well as for additional years. Mayo Clinic has filed a claim for refund for this issue which it anticipates will be rejected and plans to litigate the issue and continues to believe that Mayo Clinic is more likely than not to prevail.

Although Mayo Clinic believes it has accounted for any material adverse effect on the financial condition of Mayo Clinic as a result of these examinations, no such assurances can be given until the examinations themselves are complete.

# APPENDIX B

## Audited Consolidated Financial Report of Mayo Clinic for the Years Ended December 31, 2015 and 2014

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# Mayo Clinic

Consolidated Financial Report and
Supplemental Information
December 31, 2015

**Contents**

RSM

## Independent Auditor's Report

RSM US LLP

Board of Trustees
Mayo Clinic

**Report on the Consolidated Financial Statements**
We have audited the accompanying consolidated financial statements of Mayo Clinic and its subsidiaries (the Clinic), which comprise the consolidated statements of financial position as of December 31, 2015 and 2014, the related consolidated statements of activities and cash flows for the years 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 consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

**Auditor's Responsibility**
Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mayo Clinic and its subsidiaries as of December 31, 2015 and 2014, and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

RSM US LLP

Minneapolis, Minnesota
February 23, 2016

**Mayo Clinic**

**Consolidated Statements of Financial Position**
**December 31, 2015 and 2014 (In Millions)**

| | 2015 | 2014 |
|---|---|---|
| **Assets** | | |
| Current assets: | | |
| Cash and cash equivalents | **$ 53** | $ 55 |
| Accounts receivable for medical services, less allowances for uncollectible accounts of $531 in 2015 and $514 in 2014 (Note 2) | **1,658** | 1,495 |
| Securities lending collateral (Note 5) | **105** | 85 |
| Other receivables (Notes 10 and 15) | **273** | 242 |
| Other current assets (Note 15) | **169** | 160 |
| **Total current assets** | **2,258** | 2,037 |
| Investments (Note 4) | **7,061** | 7,179 |
| Investments under securities lending agreement (Note 5) | **111** | 91 |
| Other long-term assets (Notes 4, 10, 13 and 15) | **633** | 636 |
| Property, plant and equipment, net (Note 6) | **4,230** | 4,057 |
| **Total assets** | **$ 14,293** | $ 14,000 |
| **Liabilities and Net Assets** | | |
| Current liabilities: | | |
| Accounts payable | **$ 399** | $ 411 |
| Accrued payroll | **617** | 555 |
| Accrued employee benefits | **133** | 128 |
| Deferred revenue | **40** | 43 |
| Long-term variable-rate debt (Note 8) | **360** | 360 |
| Securities lending payable (Note 5) | **105** | 85 |
| Other current liabilities (Notes 13, 14 and 15) | **315** | 321 |
| **Total current liabilities** | **1,969** | 1,903 |
| Long-term debt, net of current portion (Note 8) | **2,388** | 2,437 |
| Accrued pension and postretirement benefits, net of current portion (Note 13) | **1,323** | 1,611 |
| Other long-term liabilities (Notes 9, 14 and 15) | **966** | 857 |
| **Total liabilities** | **6,646** | 6,808 |
| Net assets (Notes 10 and 11): | | |
| Unrestricted | **5,162** | 4,761 |
| Temporarily restricted | **1,319** | 1,323 |
| Permanently restricted | **1,166** | 1,108 |
| **Total net assets** | **7,647** | 7,192 |
| **Total liabilities and net assets** | **$ 14,293** | $ 14,000 |

See notes to consolidated financial statements.

**Mayo Clinic**

## Consolidated Statements of Activities
## Years Ended December 31, 2015 and 2014 (In Millions)

| | 2015 | | | | 2014 | | | |
|---|---|---|---|---|---|---|---|---|
| | **Unrestricted** | **Temporarily Restricted** | **Permanently Restricted** | **Total** | Unrestricted | Temporarily Restricted | Permanently Restricted | Total |
| Revenue, gains and other support: | | | | | | | | |
| Net medical service revenue (Note 2) | **$ 8,620** | **$ -** | **$ -** | **$ 8,620** | $ 8,165 | $ - | $ - | $ 8,165 |
| Grants and contracts | **386** | **-** | **-** | **386** | 375 | - | - | 375 |
| Investment return allocated to current activities (Note 4) | **206** | **27** | **-** | **233** | 156 | 17 | - | 173 |
| Contributions available for current activities | **40** | **171** | **-** | **211** | 36 | 143 | - | 179 |
| Premium revenue | **144** | **-** | **-** | **144** | 132 | - | - | 132 |
| Other (Notes 3 and 16) | **721** | **-** | **-** | **721** | 737 | - | - | 737 |
| Net assets released from restrictions (Note 10) | **206** | **(206)** | **-** | **-** | 180 | (180) | - | - |
| **Total revenue, gains and other support** | **10,323** | **(8)** | **-** | **10,315** | 9,781 | (20) | - | 9,761 |
| Expenses (Note 12): | | | | | | | | |
| Salaries and benefits | **6,371** | **-** | **-** | **6,371** | 5,872 | - | - | 5,872 |
| Supplies and services | **2,621** | **-** | **-** | **2,621** | 2,290 | - | - | 2,290 |
| Facilities | **697** | **-** | **-** | **697** | 669 | - | - | 669 |
| Finance and investment | **100** | **-** | **-** | **100** | 96 | - | - | 96 |
| **Total expenses** | **9,789** | **-** | **-** | **9,789** | 8,927 | - | - | 8,927 |
| **Income (loss) from current activities** | **534** | **(8)** | **-** | **526** | 854 | (20) | - | 834 |
| Noncurrent and other items: | | | | | | | | |
| Contributions not available for current activities, net | **(10)** | **12** | **58** | **60** | (11) | 5 | 104 | 98 |
| Unallocated investment (loss) return, net (Note 4) | **(103)** | **(8)** | **-** | **(111)** | 134 | 96 | - | 230 |
| Income tax expense (Note 7) | **(33)** | **-** | **-** | **(33)** | (32) | - | - | (32) |
| Reclassifications and other | **1** | **-** | **-** | **1** | (9) | (8) | 15 | (2) |
| **Total noncurrent and other items** | **(145)** | **4** | **58** | **(83)** | 82 | 93 | 119 | 294 |
| **Increase (decrease) in net assets before other changes in net assets** | **389** | **(4)** | **58** | **443** | 936 | 73 | 119 | 1,128 |
| Pension and other postretirement benefit adjustments (Note 13) | **12** | **-** | **-** | **12** | (1,590) | - | - | (1,590) |
| **Increase (decrease) in net assets** | **401** | **(4)** | **58** | **455** | (654) | 73 | 119 | (462) |
| Net assets at beginning of year | **4,761** | **1,323** | **1,108** | **7,192** | 5,415 | 1,250 | 989 | 7,654 |
| Net assets at end of year | **$ 5,162** | **$ 1,319** | **$ 1,166** | **$ 7,647** | $ 4,761 | $ 1,323 | $ 1,108 | $ 7,192 |

See notes to consolidated financial statements.

**Mayo Clinic**

**Consolidated Statements of Cash Flows**
**Years Ended December 31, 2015 and 2014 (In Millions)**

| | 2015 | 2014 |
|---|---|---|
| Cash flows from current activities: | | |
| Increase (decrease) in net assets | **$ 455** | $ (462) |
| Adjustments to reconcile changes in net assets to net cash provided by current activities: | | |
| Depreciation and amortization | **455** | 437 |
| Provision for uncollectible accounts | **200** | 208 |
| Net realized and unrealized gain on investments | **(28)** | (286) |
| Restricted gifts, bequests and other | **(58)** | (104) |
| Net change in accounts receivable and other current assets and liabilities | **(357)** | (204) |
| Pension and other postretirement benefits adjustments | **(288)** | 1,216 |
| Net change in other long-term assets and liabilities | **108** | (7) |
| **Net cash provided by current activities** | **487** | 798 |
| Cash flows from investing activities: | | |
| Purchase of property, plant and equipment | **(628)** | (516) |
| Purchases of investments | **(1,094)** | (901) |
| Sales and maturities of investments | **1,220** | 301 |
| **Net cash used in investing activities** | **(502)** | (1,116) |
| Cash flows from financing activities: | | |
| Restricted gifts, bequests and other | **62** | 77 |
| Borrowings on long-term debt | **-** | 300 |
| Payment of long-term debt | **(49)** | (51) |
| **Net cash provided by financing activities** | **13** | 326 |
| **Net increase (decrease) in cash and cash equivalents** | **(2)** | 8 |
| Cash and cash equivalents at beginning of year | **55** | 47 |
| Cash and cash equivalents at end of year | **$ 53** | $ 55 |

See notes to consolidated financial statements.

## Note 1. Organization and Summary of Significant Accounting Policies

**Organization:** Mayo Clinic (the Clinic) and its Arizona, Florida, Georgia, Iowa, Minnesota and Wisconsin affiliates provide comprehensive medical care and education in clinical medicine and medical sciences and conduct extensive programs in medical research. The Clinic and its affiliates also provide hospital and outpatient services, and at each major location, the clinical practice is closely integrated with advanced education and research programs. The Clinic and most of its subsidiaries have been determined to qualify as tax-exempt organizations under Section 501(c)(3) of the Internal Revenue Code (the Code) and as a public charity under Section 509(a)(2) of the Code.

**Basis of presentation:** Included in the Clinic's consolidated financial statements are all of its wholly owned or wholly controlled subsidiaries. All significant intercompany transactions have been eliminated in consolidation. In addition, these statements follow generally accepted accounting principles applicable to the not-for-profit industry as described in the Financial Accounting Standards Board's *FASB Accounting Standards Codification* (ASC) Topic 958.

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

**Change in accounting principle:** In 2015, the Clinic adopted Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) No. 2015-03, *Interest—Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, which changes the presentation of debt issuance costs. This ASU requires presentation of debt issuance costs as a direct reduction of the related debt liability. As a result of adopting ASU 2015-03, long-term assets and long-term debt were reduced by $13 for the years ended December 31, 2015 and 2014, respectively.

In addition, the Clinic adopted FASB ASU No. 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)* (Subtopic 820-10), which removes investments from the fair value hierarchy (Note 4) for which fair value is measured at net asset value (NAV) as a practical expedient. The adoption of this ASU did not impact the carrying value of the investments, but resulted in significant changes to disclosures.

**Cash and cash equivalents:** Cash and cash equivalents include currency on hand, demand deposits with banks or other financial institutions, and short-term investments with maturities of three months or less from the date of purchase, which are not managed by the Clinic's investment managers.

**Accounts receivable for medical services:** Accounts receivable for medical services are stated at estimated net realizable value. The Clinic estimates the allowances for uncollectible accounts based on historic write-offs and the aging of the accounts. Accounts are written off when collection efforts have been exhausted.

**Inventories:** Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market, determined using the first-in, first-out method.

## Note 1. Organization and Summary of Significant Accounting Policies (Continued)

**Investments:** Investments in equity and debt securities, including alternative investments, are recorded at fair value (Notes 4 and 5). Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Realized gains and losses are calculated based on the average cost method. Investment income or loss (including realized and unrealized gains and losses on investments, interest and dividends) are included in the consolidated statements of activities.

Alternative investments (principally limited partnership interests in absolute return, hedge, private equity, real estate and natural resources funds), represents the Clinic's ownership interest in the respective partnership, which is valued at NAV obtained from fund manager statements and historical audited financial statements. The investments in alternative investments may individually expose the Clinic to securities lending, short sales, and trading in futures and forward contract options and other derivative products. The Clinic's risk is limited to the investment's carrying value.

It is the Clinic's intent to maintain a long-term investment portfolio to support research, education and other activities. Accordingly, the total investment return is reported in the consolidated statements of activities in two categories. The investment return allocated to current activities is determined by a formula, which involves allocating five percent of a three-year moving average of investments related to endowments and additionally entails the matching of financing costs for the assets required for operations. Management believes this return is approximately equal to the real return that the Clinic expects to earn on its investments over the long term. The unallocated investment return, included in noncurrent and other items in the consolidated statements of activities, represents the difference between the total investment return and the amount allocated to current activities.

**Property, plant and equipment:** Property, plant and equipment are carried at cost if purchased or at fair value on the date received through affiliation or donation, less accumulated depreciation. Plant and equipment are depreciated over estimated useful lives ranging from three to fifty years using the straight-line method. Depreciation expense is reflected in facilities expense and was $455 and $437 in 2015 and 2014, respectively, and includes amortization of assets recorded under capital leases.

Costs associated with the development and installation of internal-use software are accounted for in accordance with the Intangibles—Goodwill and Other, Internal-Use Software subtopic of the FASB ASC. Accordingly, internal-use software costs are expensed or capitalized according to the provisions of the accounting standard.

**Deferred revenue:** Deferred revenue consists of payments received in advance for grant, subscription and tuition revenue. Deferred revenues are subsequently recognized as revenue in accordance with the Clinic's revenue recognition policies.

**Deferred compensation:** The Clinic offers eligible employees a nonqualified, tax-deferred compensation retirement plan. Employees defer compensation into the plan on a pretax basis. For the most part, the plan operates similar to a defined contribution plan.

### Note 1. Organization and Summary of Significant Accounting Policies (Continued)

**Asset retirement obligations:** The Clinic accounts for the estimated cost of legal obligations associated with long-lived asset retirements in accordance with the Asset Retirement and Environmental Obligations topic of the FASB ASC. The asset retirement liability, recorded in other long-term liabilities, is accreted to the present value of the estimated future costs of these obligations at the end of each period.

**Net assets:** Resources are classified for reporting purposes into three net asset categories (unrestricted, temporarily restricted and permanently restricted) according to the absence or existence of donor-imposed restrictions. Temporarily restricted net assets are those assets, including contributions and accumulated investment returns, whose use has been limited by donors to specific purposes or time periods. Permanently restricted net assets are those for which donors require the principal of the gifts to be maintained in perpetuity and provide a permanent source of income. Reclassifications of net assets are primarily the result of donor redesignations.

**Net medical service revenue:** Net medical service revenue is recognized when services are provided. The Clinic has agreements with third-party payors that provide for payments to the Clinic at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem rates. Net medical service revenue is reported at the estimated net amounts due from patients and third-party payors for services rendered. For patients that do not qualify for charity care, the Clinic recognizes revenue on the basis of its standard rates for services provided less an allowance for uncollectible accounts (or on the basis of discounted rates, if negotiated or provided by policy). Based on historical experience, a portion of the Clinic's patients will be unable or unwilling to pay for the services provided. Thus, the Clinic records a provision for uncollectible accounts related to patients in the period the services are provided.

**Grants and contracts:** Reciprocal grants and contracts revenue is recognized when the expenses have been incurred for the purpose specified by the grantor or in accordance with the terms of the agreement. Grant and contract amounts due to the Clinic are included in other receivables.

**Premium revenue:** Premium revenue represents capitated health premiums received by a managed care subsidiary from third parties and is recognized as revenue in the period in which enrollees are entitled to health care services.

**Charity and uncompensated care:** The Clinic provides health care services to patients who meet certain criteria under its Charity Care Policy without charge or at amounts less than established rates. Since the Clinic does not pursue collection of these amounts, they are not reported as revenue. The estimated cost of providing these services was $73 and $76 in 2015 and 2014, respectively, calculated by multiplying the ratio of cost to gross charges for the Clinic by the gross uncompensated charges associated with providing care to charity patients. In addition to the charges related to the direct patient care provided under the Clinic's Charity Care Policy, the Clinic has programs offered to benefit the broader community and other governmental reimbursement programs. The Clinic also participates in various state Medicaid programs for indigent patients. The estimated unreimbursable cost of providing services related to Medicaid programs totaled $476 and $385 in 2015 and 2014, respectively.

## Note 1. Organization and Summary of Significant Accounting Policies (Continued)

**Contributions:** The Clinic classifies unrestricted contributions and temporarily restricted contributions that are available for current activities as revenue, based on the lack of specific donor restriction or the presence of donor restrictions and the ability of the Clinic to meet those restrictions within the fiscal year. Permanently restricted contributions and temporarily restricted contributions that are not available for current activities are classified in noncurrent and other items in the consolidated statements of activities. Development expenses of $39 ($29 allocated to current and $10 allocated to noncurrent) and $37 ($25 allocated to current and $12 allocated to noncurrent) were incurred in 2015 and 2014, respectively. The current portion is recorded in expenses, and the noncurrent portion is netted against unrestricted contributions not available for current activities in the consolidated statements of activities. Unconditional promises to give and contributions are reported at fair value at the time of the gift. An allowance for uncollectible pledges receivable is estimated based on a combination of historical experience and specific identification. Conditional promises to give are recognized at fair value when the conditions on which they depend are substantially met or the probability that the condition will not be met is remote.

The Clinic does not imply a time restriction that expires over the useful life for gifts of long-lived assets.

The Clinic periodically receives works of art from various benefactors. These items are unique in nature and are held on display for the benefit and enjoyment of the Clinic's patients. It is the Clinic's policy to neither capitalize contributed works of art nor record the related contribution revenue.

**Income from current activities:** The Clinic's policy is to include in income from current activities all net medical service and other revenue, grants and contracts, investment return allocated to current activities, contributions available for current activities, premium revenue, net assets released from restrictions, and substantially all expenses. Contributions not available for current activities, unallocated investment return, and those items not expected to recur on a regular basis are included in noncurrent and other items in the consolidated statements of activities.

**Subsequent events:** The Clinic evaluated events and transactions occurring subsequent to December 31, 2015, through February 23, 2016, the date of issuance of the consolidated financial statements. During this period, there were no subsequent events requiring recognition in the consolidated financial statements. Additionally, there were no unrecognized events requiring disclosure.

## Note 2. Net Medical Service Revenue, Contractual Arrangements With Third-Party Payors, and Allowance for Doubtful Accounts

The Clinic provides care to patients under the Medicare program and contractual arrangements with other third-party payors. The Medicare program pays for inpatient and most outpatient services at predetermined rates. Certain hospital services are reimbursed based on allowable costs as reported in cost reports, which are subject to retroactive audit and adjustment.

Adjustments arising from reimbursement arrangements with third-party payors are accrued on an estimated basis in the period in which the services are rendered. Estimates for recognized cost report settlements can differ from actual reimbursement based on the results of subsequent reviews and cost report audits. The impact to net medical service revenue of such items was not significant in 2015 and 2014.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 2. Net Medical Service Revenue, Contractual Arrangements With Third-Party Payors, and Allowance for Doubtful Accounts (Continued)

Future changes in the Medicare program and reduction of funding levels could have an adverse effect on the Clinic. Net medical service revenue under the Medicare program represented approximately 26 percent and 25 percent of total net medical service revenue for 2015 and 2014, respectively. At December 31, 2015 and 2014, approximately 15 percent and 16 percent, respectively, of accounts receivable for medical services was due from the Medicare program.

As a service to the patient, the Clinic bills third-party payors directly and bills the patient when the patient's liability is determined. Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Clinic analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Clinic analyzes contractually due amounts and provides contractual allowances based on these amounts. Additionally, an allowance for doubtful accounts and a provision for uncollectible accounts is provided for expected uncollectible deductibles and copayments on accounts for which the patient is responsible. For receivables associated with self-pay patients, the Clinic records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Clinic's allowance for doubtful accounts was 24.3 percent and 25.6 percent of accounts receivable at December 31, 2015 and 2014, respectively. In addition, the Clinic's write-offs were $181 and $133 for the years ended December 31, 2015 and 2014, respectively. The Clinic has not significantly changed its charity care policies in 2015.

Net medical service revenue for the years ended December 31 consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Medical service revenue (net of contractual allowances and discounts) | $ 8,817 | $ 8,370 |
| Provision for uncollectible accounts | (197) | (205) |
| Net medical service revenue | $ 8,620 | $ 8,165 |

The Clinic recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. Medical service revenue, net of contractual allowances and discounts (but before the provision for uncollectible accounts), recognized in the years ended December 31 from these major payor sources, is as follows:

| | 2015 | 2014 |
|---|---|---|
| Third-party payors | $ 8,420 | $ 7,969 |
| Self-pay | 397 | 401 |
| Total all payors | $ 8,817 | $ 8,370 |

## Note 3. Incentive Revenue

The Health Information Technology for Economic and Clinic Health (HITECH) portion of the American Recovery and Reinvestment Act of 2009 included $27 billion in incentives through Medicare and Medicaid reimbursement systems to foster electronic health record (EHR) adoption. In order to be eligible for EHR incentive funding, eligible hospitals and professionals must use a certified EHR, report quality measures, and achieve "meaningful use," as defined by HITECH. The Clinic is entitled to receive Medicare and Medicaid incentive payments for the adoption of certified EHR technology for its eligible hospitals and employed physicians, as the Clinic believes it has satisfied the statutory and regulatory requirements. The Clinic applies the gain contingency model for recognizing incentive revenue. As a result, incentives earned totaled $18 and $36 for the years ended December 31, 2015 and 2014, respectively, and are included in other revenue. Income from incentive payments is subject to retrospective adjustments, as the incentive payments are calculated using Medicare cost report data that is subject to audit. Additionally, the Clinic's compliance with the meaningful use criteria is subject to audit by the federal government.

## Note 4. Fair Value Measurements

The Clinic holds certain financial instruments that are required to be measured at fair value on a recurring basis. The valuation techniques used to measure fair value under the Fair Value Measurements and Disclosures topic of the FASB ASC are based upon observable and unobservable inputs. The standard establishes 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.

**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 same term of the financial instrument.

**Level 3:** Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. The Clinic's policy is to recognize transfers in and transfers out as of the actual date of the event or change in circumstances that caused the transfer. There were no significant transfers or activity within investment levels in 2015 or 2014.

**Notes to Consolidated Financial Statements (In Millions)**

## Note 4. Fair Value Measurements (Continued)

The following tables present the financial instruments carried at fair value as of December 31, 2015 and 2014, by caption on the consolidated statements of financial position categorized by the valuation hierarchy defined above:

| | December 31, 2015 | | | | |
|---|---|---|---|---|---|
| | Level 1 | Level 2 | Level 3 | NAV | Total Fair Value |
| Assets: | | | | | |
| Securities lending collateral | $ 105 | $ - | $ - | $ - | $ 105 |
| Investments: | | | | | |
| Cash equivalents | 720 | - | - | - | 720 |
| Fixed-income securities: | | | | | |
| U.S. government | - | 175 | - | - | 175 |
| U.S. government agencies | - | 217 | - | - | 217 |
| U.S. corporate | - | 309 | 8 | - | 317 |
| Foreign | - | 17 | - | - | 17 |
| Common and preferred stocks: | | | | | |
| U.S. | 439 | - | 2 | - | 441 |
| Foreign | 419 | - | - | - | 419 |
| Funds: | | | | | |
| Fixed-income | 390 | - | - | - | 390 |
| Equities | 489 | 118 | - | - | 607 |
| Other investments | 16 | - | - | - | 16 |
| Less securities under lending agreement | (111) | - | - | - | (111) |
| Investments at NAV | - | - | - | 3,853 | 3,853 |
| Total investments | 2,362 | 836 | 10 | 3,853 | 7,061 |
| Investments under securities lending agreement | 111 | - | - | - | 111 |
| Other long-term assets: | | | | | |
| Trust receivables | 86 | 33 | 54 | - | 173 |
| Technology-based ventures | - | - | 37 | - | 37 |
| Total other long-term assets | 86 | 33 | 91 | - | 210 |
| Total assets at fair value | $ 2,664 | $ 869 | $ 101 | $ 3,853 | $ 7,487 |
| Liabilities: | | | | | |
| Securities lending payable | $ 105 | $ - | $ - | $ - | $ 105 |
| Total liabilities at fair value | $ 105 | $ - | $ - | $ - | $ 105 |

**Notes to Consolidated Financial Statements (In Millions)**

## Note 4. Fair Value Measurements (Continued)

| | December 31, 2014 | | | | |
|---|---|---|---|---|---|
| | Level 1 | Level 2 | Level 3 | NAV | Total Fair Value |
| Assets: | | | | | |
| Securities lending collateral | $ 85 | $ - | $ - | $ - | $ 85 |
| Investments: | | | | | |
| Cash equivalents | 1,145 | - | - | - | 1,145 |
| Fixed-income securities: | | | | | |
| U.S. government | - | 109 | - | - | 109 |
| U.S. government agencies | - | 225 | - | - | 225 |
| U.S. corporate | - | 319 | 20 | - | 339 |
| Foreign | - | 90 | - | - | 90 |
| Common and preferred stocks: | | | | | |
| U.S. | 411 | - | - | - | 411 |
| Foreign | 391 | - | - | - | 391 |
| Funds: | | | | | |
| Fixed-income | 349 | - | - | - | 349 |
| Equities | 398 | 111 | - | - | 509 |
| Other investments | 4 | - | - | - | 4 |
| Less securities under lending agreement | (91) | - | - | - | (91) |
| Investments at NAV | - | - | - | 3,698 | 3,698 |
| Total investments | 2,607 | 854 | 20 | 3,698 | 7,179 |
| Investments under securities lending agreement | 91 | - | - | - | 91 |
| Other long-term assets: | | | | | |
| Trust receivables | 95 | 34 | 56 | - | 185 |
| Technology-based ventures | - | - | 30 | - | 30 |
| Total other long-term assets | 95 | 34 | 86 | - | 215 |
| Total assets at fair value | $ 2,878 | $ 888 | $ 106 | $ 3,698 | $ 7,570 |
| Liabilities: | | | | | |
| Securities lending payable | $ 85 | $ - | $ - | $ - | $ 85 |
| Total liabilities at fair value | $ 85 | $ - | $ - | $ - | $ 85 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 4. Fair Value Measurements (Continued)

Following is a description of the Clinic's valuation methodologies for assets and liabilities measured at fair value. Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources, including market participants, dealers and brokers. Level 3 primarily consists of trusts recorded at fair value based on the underlying value of the assets in the trust or discounted cash flow of the expected payment streams. The trusts reported as Level 3 are primarily perpetual trusts managed by third parties invested in stocks, mutual funds, and fixed-income securities that are traded in active markets with observable inputs, which would result in Level 1 and 2 hierarchal reporting. However, since the Clinic will never receive the trust assets, these perpetual trusts are reported as Level 3.

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

The following information pertains to those alternative investments recorded at NAV in accordance with the Fair Value Measurements and Disclosures topic of the FASB ASC.

At December 31, 2015, alternative investments recorded at NAV consisted of the following:

| | Fair Value | Unfunded Commitment | Redemption Frequency (If Currently Eligible) | Redemption Notice Period |
|---|---|---|---|---|
| Absolute return/hedge funds (a) | $ 2,175 | $ - | Monthly to annually | 30–90 days |
| Private partnerships (b) | 1,678 | 1,023 | | |
| | $ 3,853 | $ 1,023 | | |

At December 31, 2014, alternative investments recorded at NAV consisted of the following:

| | Fair Value | Unfunded Commitment | Redemption Frequency (If Currently Eligible) | Redemption Notice Period |
|---|---|---|---|---|
| Absolute return/hedge funds (a) | $ 2,240 | $ - | Monthly to annually | 30–90 days |
| Private partnerships (b) | 1,458 | 913 | | |
| | $ 3,698 | $ 913 | | |

### Note 4. Fair Value Measurements (Continued)

(a) This category includes investments in absolute return/hedge funds, which are actively managed commingled investment vehicles that derive the majority of their returns from factors other than the directional flow of the markets in which they invest. Representative strategies include high-yield credit, distressed debt, merger arbitrage, relative value, and long-short equity strategies. The fair values of the investments in this category have been estimated using the NAV per share of the investments. Investments in this category generally carry "lockup" restrictions that do not allow investors to seek redemption in the first year after acquisition. Following the initial lockup period, liquidity is generally available monthly, quarterly or annually following a redemption request. Over 90 percent of the investments in this category have at least annual liquidity.

(b) This category includes limited partnership interests in closed-end funds that focus on venture capital, private equity, real estate and resource-related strategies. The fair values of the investments in this category have been estimated using the NAV of the Clinic's ownership interest in partners' capital. Distributions from each fund will be received as the underlying investments of the funds are liquidated. It is estimated that the underlying assets of most funds will generally be liquidated over a seven- to 10-year period.

From time to time, the Clinic invests directly in certain derivative contracts that do not qualify for hedge accounting and are recorded at fair value in investments. Changes in fair value are reported as a component of net unrealized gains or losses in the investment returns. These contracts are used in the Clinic's investment management program to minimize certain investment risks. During the years ended December 31, 2015 and 2014, the realized and unrealized loss from derivative contracts totaled $41 and $12, respectively.

The carrying values of cash, cash equivalents, short-term investments, accounts receivable, accounts payable and accrued expenses are reasonable estimates of their fair values due to the short-term nature of these financial instruments. The estimated fair value of long-term debt (Note 8), based on quoted market prices for the same or similar issues (Level 2), was approximately $32 and $127 more than its carrying value at December 31, 2015 and 2014, respectively.

The Clinic uses various external investment managers to diversify the investments in alternative assets. The largest allocation to any alternative investment strategy manager as of December 31, 2015 and 2014, is $253 (6.6 percent) and $276 (7.5 percent), respectively.

The Clinic is required to maintain funds held by trustees under bond indentures and other arrangements. The trustee-held investments, which primarily consist of mutual funds, were $500 and $482, respectively, at December 31, 2015 and 2014, which includes segregated investments for deferred compensation plans of $421 and $402 at December 31, 2015 and 2014, respectively.

At December 31, 2015 and 2014, cash and mutual funds included segregated investments owned by Mayo Foundation for Medical Education and Research, a wholly owned subsidiary of Mayo Clinic, for gift annuity reserves of $100 and $103, respectively.

The Clinic has internally designated investment balances of $1,833 and $1,765 at December 31, 2015 and 2014, respectively, for research, education, and capital replacement and expansion.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 4. Fair Value Measurements (Continued)

Investment return consisted of the following for the years ended December 31:

| | 2015 | 2014 |
|---|---|---|
| Dividends and interest | $ 94 | $ 117 |
| Net realized gains | 189 | 166 |
| Net change in unrealized gains (losses) | (161) | 120 |
| | $ 122 | $ 403 |

Investment return (Note 1) is reported in the consolidated statements of activities as follows for the years ended December 31:

| | 2015 | 2014 |
|---|---|---|
| Investment return allocated to current activities | $ 233 | $ 173 |
| Unallocated investment return, net | (111) | 230 |
| | $ 122 | $ 403 |

### Note 5. Securities Lending

The Clinic has an arrangement with its investment custodian to lend Clinic securities to approved brokers in exchange for a fee. Among other provisions that limit the Clinic's risk, the securities lending agreement specifies that the custodian is responsible for lending securities and obtaining adequate collateral from the borrower. Collateral is limited to cash, government securities, and irrevocable letters of credit. Investments are loaned to various brokers and are returnable on demand. In exchange, the Clinic receives collateral. The cash collateral is shown as both an asset and a liability on the consolidated statements of financial position.

At December 31, 2015 and 2014, the aggregate market value of securities on loan under securities lending agreements totaled $111 and $91, respectively, and the total value of the collateral supporting the securities is $116 and $94, respectively, which represents 104 percent and 103 percent of the value of the securities on loan at December 31, 2015 and 2014, respectively. The cash portion of the collateral supporting the securities as of December 31, 2015 and 2014, is $105 and $85, respectively. Noncash collateral provided to the Clinic is not recorded in the consolidated statements of financial position, as the collateral may not be sold or repledged. The Clinic's claim on such collateral is limited to the market value of loaned securities. In the event of nonperformance by the other parties to the securities lending agreements, the Clinic could be exposed to some loss.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 6. Property, Plant and Equipment, Net

Property, plant and equipment, net at December 31 consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Land | $ 276 | $ 269 |
| Buildings and improvements | 5,135 | 4,953 |
| Furniture and equipment | 3,406 | 3,081 |
| | 8,817 | 8,303 |
| Accumulated depreciation and amortization | (4,998) | (4,659) |
| | 3,819 | 3,644 |
| Construction in progress | 411 | 413 |
| | $ 4,230 | $ 4,057 |

The above costs and accumulated depreciation include costs for capitalized software, including costs capitalized in accordance with the Intangibles—Goodwill and Other, Internal-Use Software subtopic of the FASB ASC Topic 350. The total cost for capitalized software was $543 and $508, and the total accumulated amortization was $463 and $417 at December 31, 2015 and 2014, respectively. Amortization expense for capitalized software was $47 and $48 for 2015 and 2014, respectively.

### Note 7. Income Taxes

Most of the income received by the Clinic and its subsidiaries is exempt from taxation under Section 501(a) of the Internal Revenue Code. Some of its subsidiaries are taxable entities, and some of the income received by otherwise exempt entities is subject to taxation as unrelated business income (UBI). The Clinic or its subsidiaries file income tax returns in the U.S. federal, various state, and foreign jurisdictions. The statutes of limitations for tax years 2012 through 2014 remain open in the major U.S. taxing jurisdictions in which the Clinic and subsidiaries are subject to taxation. In addition, for all tax years prior to 2012 generating or utilizing a net operating loss (NOL), tax authorities can adjust the amount of NOL carryforward to subsequent years.

The Internal Revenue Service (IRS) performed an examination of the tax and information returns of the Clinic and two subsidiaries for 2005 and 2006. As a result of the audit by the IRS, one remaining entity had extended the statutes of limitations for tax years 2005 through 2009 until June 30, 2015. The IRS has concluded a limited-scope audit of one entity for tax year 2011 and has extended the statutes of limitations until December 31, 2015, for that entity for 2010–2011. As of December 31, 2015, the IRS proposed an $11 tax and interest assessment for 2005 through 2012 that the Clinic paid. The Clinic has filed a claim for refund for these amounts, and anticipates litigating any denial of such claims, which management has taken into consideration during its determination of unrecognized tax benefits.

The Clinic has recorded $6 tax, including interest and penalties for uncertain tax positions, during the year ended December 31, 2015. It is not anticipated that a significant change in the reserve will occur over the next 12 months.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 7. Income Taxes (Continued)

The Clinic's practice is to recognize interest and/or penalties related to income tax matters in income tax expense. The components of tax expense are as follows:

| | December 31 | |
|---|---|---|
| | 2015 | 2014 |
| Current—federal | $ 27 | $ 26 |
| Current—state | 3 | 2 |
| | 30 | 28 |
| Deferred—federal | - | 4 |
| Deferred—state | 3 | 1 |
| Change in valuation allowance | - | (1) |
| | 3 | 4 |
| Total | $ 33 | $ 32 |

Cash payments for income taxes were $24 and $47 for the years ended December 31, 2015 and 2014, respectively.

The Clinic records deferred income taxes due to temporary differences between financial reporting and tax reporting for certain assets and liabilities of its taxable activities. The state deferred tax asset was impacted by a decrease in the state effective rate as a result of combined group filing changes. Following is a summary of the components of deferred taxes as of December 31:

| | 2015 | 2014 |
|---|---|---|
| Deferred compensation | $ 18 | $ 21 |
| Pension | 15 | 16 |
| Postretirement benefits | 3 | 3 |
| Other | 8 | 5 |
| Total deferred tax asset | 44 | 45 |
| Deferred tax liability | (6) | (4) |
| Valuation allowance, net of effects from affiliation | (1) | (1) |
| Net deferred tax asset | $ 37 | $ 40 |
| Current | $ 3 | $ 2 |
| Noncurrent | 34 | 38 |
| | $ 37 | $ 40 |

As of December 31, 2015, the Clinic had no federal net operating losses.

**Notes to Consolidated Financial Statements (In Millions)**

## Note 8. Financing

Long-term debt at December 31 consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| City of Rochester, Minnesota Revenue Bonds issued in various series, subject to variable interest rates to a maximum rate of 15.00% (the average rate was 0.04% in 2015 and 0.07% in 2014), principal due in varying amounts from 2019 through 2052 | $ 810 | $ 810 |
| City of Rochester, Minnesota Revenue Bonds issued in various series with fixed rates of interest ranging from 4.00% to 5.00%, principal due in varying amounts from 2028 through 2041 | 690 | 690 |
| Industrial Development Authority of the City of Phoenix, Arizona issued in various series, subject to variable interest rates to a maximum rate of 10.00% (the average rate was 0.02% in 2015 and 0.04% in 2014), principal due in varying amounts from 2048 through 2052 | 180 | 180 |
| Industrial Development Authority of the County of Maricopa Hospital Revenue Bonds issued in various series, interest rate at 5.00%, principal due in varying amounts from 2031 through 2036 | 50 | 50 |
| Jacksonville Economic Development Commission Health Care Facilities Revenue Bonds issued in various series, interest rate at 5.00%, principal due in varying amounts from 2031 to 2036 | 125 | 125 |
| Wisconsin Health and Educational Facilities Authority Revenue Bonds, Series 2008, issued in various series, with fixed interest rates ranging from 4.00% to 5.75%, principal due in varying amounts through 2030 | 74 | 78 |
| Mayo Clinic Taxable Bonds issued with fixed interest rates ranging from 3.774% to 4.00%, principal due in varying amounts from 2039 to 2047 | 600 | 600 |
| Fixed-rate notes, payable to banks, interest rate at 2.01%, principal due in 2016 | 45 | 90 |
| Fixed-rate notes, payable to an insurance company, interest rate at 4.71%, principal due in equal amounts from 2042 through 2046 | 215 | 215 |
| Other notes payable | 16 | 17 |
| Unamortized discounts and premiums, net | 5 | 5 |
| Debt issuance cost | (13) | (13) |
| | 2,797 | 2,847 |
| Long-term variable-rate debt classified as current | (360) | (360) |
| Current maturities included in other current liabilities | (49) | (50) |
| | $ 2,388 | $ 2,437 |

The Clinic's outstanding revenue bond issues are limited obligations of various issuing authorities payable solely by the Clinic pursuant to loan agreements between the borrowing entities and the issuing authorities. Under various financing agreements, the Clinic must meet certain operating and financial performance covenants.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 8. Financing (Continued)

At December 31, 2015, the $990 of variable-rate bonds consist of variable-rate demand revenue bonds. In conjunction with the issuance of the variable-rate demand revenue bonds, the Clinic has entered into various bank standby purchase and credit agreements in the amount of $630 that expire at various dates commencing January 2017. Under the terms of these agreements, the bank will make liquidity loans to the Clinic in the amount necessary to purchase a portion of the variable-rate demand revenue bonds if not remarketed. The liquidity loans would be payable over a three- to five-year period, with the first payment due after December 31, 2016. The Clinic has provided self-liquidity for the remaining $360 of variable-rate demand revenue bonds, which have been classified as current in the accompanying consolidated statements of financial position.

All fixed-rate interest revenue bonds are callable from 2016 to 2047 at the option of the Clinic, at a redemption price of 100 percent of the principal amount or at a price based on U.S. Treasury rates at the time of redemption.

The following are scheduled maturities of long-term debt for each of the next five years, assuming the variable-rate demand revenue bonds are remarketed and the standby purchase agreements renewed. As described above, if such bonds are not remarketed, $360 may be due in 2016 and $630 may be due in years from 2017 to 2021.

| Years ending December 31: | |
|---|---|
| 2016 | $ 49 |
| 2017 | 4 |
| 2018 | 4 |
| 2019 | 6 |
| 2020 | 7 |

Interest payments on long-term debt, net of amounts capitalized for 2015 and 2014, totaled $79 and $81, respectively. The amount of interest capitalized, net of related interest income, was $3 and $5 during 2015 and 2014, respectively. Interest expense totaled $79 and $80 for 2015 and 2014, respectively.

At December 31, 2015 and 2014, the Clinic had unsecured lines of credit available with banks totaling $425 and $325, respectively, with varying renewable terms and interest up to 2.5 percent over various published rates. There were no amounts drawn at December 31, 2015 and 2014.

**Notes to Consolidated Financial Statements (In Millions)**

## Note 9. Lease Commitments

Certain leases are classified as capital leases. The leased assets are included as part of property, plant and equipment (Note 6), and the capital lease obligations of $27 and $28 as of December 31, 2015 and 2014, respectively, are recorded in other current and long-term liabilities. Other leases are classified as operating and are not capitalized. The payments on such leases are recorded as expense.

Details of the capitalized lease assets are as follows at December 31:

| | 2015 | 2014 |
|---|---|---|
| Buildings and equipment | $ 34 | $ 34 |
| Furniture and equipment | 5 | 4 |
| | 39 | 38 |
| Accumulated depreciation | (11) | (9) |
| | $ 28 | $ 29 |

Rental expense incurred for operating leases was $28 and $27 for the years ended December 31, 2015 and 2014, respectively.

At December 31, 2015, the estimated future minimum lease payments under noncancellable operating leases and capital leases were as follows:

| | Operating | Capital |
|---|---|---|
| Years ending December 31: | | |
| 2016 | $ 18 | $ 3 |
| 2017 | 15 | 3 |
| 2018 | 10 | 3 |
| 2019 | 9 | 2 |
| 2020 | 6 | 3 |
| Thereafter | 30 | 20 |
| Minimum lease payments | $ 88 | 34 |
| Less amount representing interest | | (7) |
| Net minimum lease payments under capital leases | | $ 27 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 10. Contributions and Restricted Expenditures

The Clinic receives unrestricted, temporarily restricted and permanently restricted contributions in support of research, education and clinical activities.

Temporarily restricted net assets were available for the following at December 31:

| | 2015 | 2014 |
|---|---|---|
| Research | $ 582 | $ 554 |
| Education | 260 | 274 |
| Buildings and equipment | 16 | 24 |
| Charity care | 48 | 51 |
| Clinical | 87 | 91 |
| Other | 40 | 37 |
| Pledges and trusts | 286 | 292 |
| | $ 1,319 | $ 1,323 |

Permanently restricted net assets at December 31 are summarized below, the income from which is expendable to support the following:

| | 2015 | 2014 |
|---|---|---|
| Research | $ 644 | $ 620 |
| Education | 206 | 188 |
| Charity care | 17 | 12 |
| Clinical | 57 | 51 |
| Other | 28 | 18 |
| Pledges and trusts | 214 | 219 |
| | $ 1,166 | $ 1,108 |

Net assets were released from donor restrictions as expenditures were made, which satisfied the following restricted purposes for the years ended December 31:

| | 2015 | 2014 |
|---|---|---|
| Research | $ 146 | $ 124 |
| Education | 24 | 21 |
| Buildings and equipment | 9 | 12 |
| Other | 27 | 23 |
| | $ 206 | $ 180 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 10. Contributions and Restricted Expenditures (Continued)

At December 31, outstanding pledges from various corporations, foundations and individuals, included in other receivables and other long-term assets, were as follows:

| | 2015 | 2014 |
|---|---|---|
| Pledges due: | | |
| In less than one year | $ 117 | $ 107 |
| In one to five years | 217 | 219 |
| In more than five years | 22 | 26 |
| | 356 | 352 |
| Allowance for uncollectible pledges and discounts | (13) | (16) |
| | $ 343 | $ 336 |

Estimated cash flows from pledge receivables due after one year are discounted using a risk-adjusted rate, ranging from 0.92 percent to 6.23 percent, that is commensurate with the pledges' due dates and established in the year the pledge is received.

The Clinic has received interests in various trusts, primarily split-interest, which are included in other long-term assets. The trusts, which are recorded at fair value based on the underlying value of the assets in the trust or discounted cash flow of the expected payment streams, were $173 and $185 at December 31, 2015 and 2014, respectively.

### Note 11. Endowment

The Clinic's endowment consists of approximately 1,500 individual funds established for a variety of purposes. The endowment includes both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments (board-designated funds). Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions. The Board of Trustees retains the right to re-designate board-designated funds.

The Board of Trustees of the Clinic has interpreted the Minnesota State Prudent Management of Institutional Funds Act (SPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Clinic classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (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 remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by SPMIFA.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 11. Endowment (Continued)

In accordance with SPMIFA, the Clinic considers the following factors in making a determination to appropriate or accumulate donor-restricted funds:

1. The duration and preservation of the fund
2. The purposes of the Clinic and the donor-restricted endowment fund
3. General economic conditions
4. The possible effect of inflation and deflation
5. The expected total return from income and the appreciation of investments
6. Other resources of the Clinic
7. The investment policies of the Clinic

The Clinic has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Clinic must hold in perpetuity or for a donor-specified period(s) as well as board-designated funds. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment management costs, of at least five percent over the long term. Actual returns in any given year may vary from this amount.

To satisfy its long-term rate-of-return objectives, the Clinic 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 Clinic targets a diversified asset allocation that places a greater emphasis on equity-based and alternative investments to achieve its long-term objective within prudent risk constraints.

The Clinic has a policy of appropriating for distribution each year five percent of its endowment fund's moving average fair value over the prior 36 months as of September 30 of the preceding fiscal year in which the distribution is planned. In establishing this policy, the Clinic considered the long-term expected return on its endowment. Accordingly, over the long term, the Clinic expects the current spending policy to allow its endowment to grow at an average of the long-term rate of inflation. This is consistent with the Clinic's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specific term as well as to provide additional real growth through new gifts and investment return.

At December 31, 2015, the endowment net asset composition by type of fund consisted of the following:

| | Unrestricted | Temporarily Restricted | Permanently Restricted | Total |
|---|---|---|---|---|
| Donor-restricted funds | $ - | $ 628 | $ 1,166 | $ 1,794 |
| Board-designated funds | 1,582 | - | - | 1,582 |
| Total funds | $ 1,582 | $ 628 | $ 1,166 | $ 3,376 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 11. Endowment (Continued)

Changes in endowment net assets for the fiscal year ended December 31, 2015, consisted of the following:

| | Unrestricted | Temporarily Restricted | Permanently Restricted | Total |
|---|---|---|---|---|
| Endowment net assets, beginning of year | $ 1,500 | $ 677 | $ 1,108 | $ 3,285 |
| Investment return: | | | | |
| Investment income | 17 | 17 | - | 34 |
| Net appreciation (depreciation) (realized and unrealized) | (4) | 5 | - | 1 |
| Total investment return | 13 | 22 | - | 35 |
| Contributions | - | - | 58 | 58 |
| Appropriation of endowment assets for expenditure | (65) | (71) | - | (136) |
| Other changes: | | | | |
| Transfers to create board-designated endowment funds | 134 | - | - | 134 |
| Endowment net assets, end of year | $ 1,582 | $ 628 | $ 1,166 | $ 3,376 |

At December 31, 2014, the endowment net asset composition by type of fund consisted of the following:

| | Unrestricted | Temporarily Restricted | Permanently Restricted | Total |
|---|---|---|---|---|
| Donor-restricted funds | $ - | $ 677 | $ 1,108 | $ 1,785 |
| Board-designated funds | 1,500 | - | - | 1,500 |
| Total funds | $ 1,500 | $ 677 | $ 1,108 | $ 3,285 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 11. Endowment (Continued)

Changes in endowment net assets for the fiscal year ended December 31, 2014, consisted of the following:

| | Unrestricted | Temporarily Restricted | Permanently Restricted | Total |
|---|---|---|---|---|
| Endowment net assets, beginning of year | $ 1,157 | $ 625 | $ 989 | $ 2,771 |
| Investment return: | | | | |
| Investment income | 21 | 24 | - | 45 |
| Net appreciation (realized and unrealized) | 76 | 85 | - | 161 |
| Total investment return | 97 | 109 | - | 206 |
| Contributions | - | - | 104 | 104 |
| Appropriation of endowment assets for expenditure | (56) | (57) | - | (113) |
| Other changes: | | | | |
| Transfers to create board-designated endowment funds | 309 | - | - | 309 |
| Reclassifications | (7) | - | 15 | 8 |
| Endowment net assets, end of year | $ 1,500 | $ 677 | $ 1,108 | $ 3,285 |

### Note 12. Functional Expenses

The expenses reported in the consolidated statements of activities for the years ended December 31, 2015 and 2014, supported the following:

| | 2015 | 2014 |
|---|---|---|
| Patient care | $ 7,343 | $ 6,756 |
| Lab and technology ventures | 1,050 | 834 |
| Research | 659 | 642 |
| Graduate and other education | 286 | 274 |
| General and administrative | 259 | 236 |
| Development expenses | 29 | 25 |
| Other activities | 163 | 160 |
| | $ 9,789 | $ 8,927 |

**Notes to Consolidated Financial Statements (In Millions)**

## Note 13. Employee Benefit Programs

The Clinic serves as plan sponsor for several defined benefit pension funds and other postretirement benefits.

Included in other changes in unrestricted net assets at December 31, 2015 and 2014, are the following amounts, respectively, that have not yet been recognized in net periodic cost: unrecognized actuarial losses of $2,794 and $2,924 and unrecognized prior service benefit of $618 and $733. Actuarial losses are amortized as a component of net periodic pension cost, only if the losses exceed ten percent of the greater of the projected benefit obligation or the fair value of plan assets. Unrecognized prior service benefits are amortized on a straight-line basis over the estimated life of plan participants. The unrecognized actuarial losses and prior service benefit included in net assets are expected to be recognized in net periodic pension cost during the year ending December 31, 2016, in the amount of $126 and $113, respectively.

Changes in plan assets and benefit obligations recognized in unrestricted net assets during 2015 and 2014 included the following:

| | 2015 | 2014 |
|---|---|---|
| Current-year actuarial gain (loss) | $ (33) | $ (1,541) |
| Amortization of actuarial loss | 161 | 85 |
| Current-year prior service cost | (1) | (15) |
| Amortization of prior service credit | (115) | (119) |
| Pension and other postretirement benefit adjustments | $ 12 | $ (1,590) |

**Pension plans:**

***Obligations and funded status:*** Following is a summary of the changes in the benefit obligation and plan assets, the resulting funded status of the qualified and nonqualified pension plans, and accumulated benefit obligation as of and for the years ended December 31:

| | 2015 | | 2014 | |
|---|---|---|---|---|
| | Qualified | Nonqualified | Qualified | Nonqualified |
| Change in projected benefit obligation: | | | | |
| Benefit obligation, beginning of year | $ 7,353 | $ 3 | $ 5,839 | $ 3 |
| Service cost | 393 | - | 220 | - |
| Interest cost | 307 | - | 295 | - |
| Actuarial loss (gain) | (371) | - | 1,461 | - |
| Benefits paid | (371) | (1) | (462) | - |
| Estimated benefit obligation at end of year | $ 7,311 | $ 2 | $ 7,353 | $ 3 |
| Change in plan assets: | | | | |
| Fair value of plan assets, beginning of year | $ 6,556 | $ - | $ 6,181 | $ - |
| Actual return on plan assets | 102 | - | 427 | - |
| Employer contributions | 505 | 1 | 410 | - |
| Benefits paid | (371) | (1) | (462) | - |
| Fair value of plan assets at end of year | $ 6,792 | $ - | $ 6,556 | $ - |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 13. Employee Benefit Programs (Continued)

| | Pension Benefits | | | |
|---|---|---|---|---|
| | 2015 | | 2014 | |
| | Qualified | Nonqualified | Qualified | Nonqualified |
| Funded status of the plan | $ (519) | $ (2) | $ (797) | $ (3) |
| Accumulated benefit obligation | $ 7,202 | $ 2 | $ 7,289 | $ 3 |

Amounts recognized in the consolidated statements of financial position consist of the following at December 31:

| | 2015 | | 2014 | |
|---|---|---|---|---|
| | Qualified | Nonqualified | Qualified | Nonqualified |
| Noncurrent asset | $ - | $ - | $ - | $ - |
| Current liabilities | - | - | - | - |
| Noncurrent liabilities | (519) | (2) | (797) | (3) |
| Net amount recognized | $ (519) | $ (2) | $ (797) | $ (3) |

Components of net periodic benefit cost are as follows at December 31:

| | 2015 | | 2014 | |
|---|---|---|---|---|
| | Qualified | Nonqualified | Qualified | Nonqualified |
| Service cost | $ 393 | $ - | $ 220 | $ - |
| Interest cost | 307 | - | 295 | - |
| Expected return on plan assets | (511) | - | (466) | - |
| Amortization of unrecognized: | | | | |
| Prior service benefit | (61) | - | (60) | - |
| Net actuarial loss | 158 | - | 82 | - |
| Net periodic benefit cost | $ 286 | $ - | $ 71 | $ - |

***Plan assets:*** The largest of the pension funds is the Mayo Clinic Master Retirement Trust Plan, which holds $6,688 of the $6,792 in combined plan assets at December 31, 2015. The investment policies described below apply to the Mayo Clinic Master Retirement Trust Plan (the Plan).

The Plan employs a global, multi-asset approach in managing its retirement plan assets. This approach is designed to maximize risk-adjusted returns over a long-term investment horizon, consistent with the nature of the pension liabilities being funded. The plan asset portfolio's target allocation for total return investment strategies, which include public equities, private equities, absolute return, and real assets, is 80 percent. The portfolio's target fixed-income exposure is 20 percent. The fixed-income exposure may include the use of long-term interest rate swap contracts structured to increase the portfolio's interest rate sensitivity and thereby provide a hedge of the plan liabilities resulting from falling long-term interest rates. Investments in private equities, real assets, and absolute return strategies are held to improve diversification and thereby enhance long-term, risk-adjusted returns. However, recognizing that these investments are not as liquid as publicly traded stocks and bonds, portfolio investment policies limit overall exposure to these assets. The portfolio's allocation to private equities and real assets is limited to a maximum of 25 percent (with a target allocation of 20 percent), and exposure to absolute return strategies is limited to a maximum of 35 percent (with a target of 28 percent). The Clinic reviews performance, asset allocation, and risk management reports for plan asset portfolios on a monthly basis.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 13. Employee Benefit Programs (Continued)

The fair values of the Plan's assets at December 31, 2015, by asset category are as follows:

| Assets | Quoted Prices in Active Markets for Identical Assets (Level 1) | Significant Observable Inputs (Level 2) | Significant Unobservable Inputs (Level 3) | NAV | Total |
|---|---|---|---|---|---|
| Cash and cash equivalents | $ 295 | $ 23 | $ - | $ - | $ 318 |
| Fixed-income securities: | | | | | |
| U.S. government | - | 157 | - | - | 157 |
| U.S. government agencies | - | 108 | - | - | 108 |
| U.S. corporate | - | 252 | - | - | 252 |
| Foreign | - | 21 | - | - | 21 |
| Common and preferred stocks: | | | | | |
| U.S. | 503 | 33 | 14 | - | 550 |
| Foreign | 428 | - | - | - | 428 |
| Funds: | | | | | |
| Fixed-income | 200 | - | - | - | 200 |
| Equities | 174 | 203 | - | - | 377 |
| Investments at NAV | - | - | - | 4,277 | 4,277 |
| Total investments | $ 1,600 | $ 797 | $ 14 | $ 4,277 | $ 6,688 |

The fair values of the Plan's assets at December 31, 2014, by asset category are as follows:

| Assets | Quoted Prices in Active Markets for Identical Assets (Level 1) | Significant Observable Inputs (Level 2) | Significant Unobservable Inputs (Level 3) | NAV | Total |
|---|---|---|---|---|---|
| Cash and cash equivalents | $ 241 | $ 10 | $ - | $ - | $ 251 |
| Fixed-income securities: | | | | | |
| U.S. government | - | 136 | - | - | 136 |
| U.S. government agencies | 23 | 111 | - | - | 134 |
| U.S. corporate | - | 245 | - | - | 245 |
| Foreign | - | 55 | - | - | 55 |
| Common and preferred stocks: | | | | | |
| U.S. | 478 | - | 26 | - | 504 |
| Foreign | 408 | - | - | - | 408 |
| Funds: | | | | | |
| Fixed-income | 170 | - | - | - | 170 |
| Equities | 145 | 190 | - | - | 335 |
| Investments at NAV | - | - | - | 4,209 | 4,209 |
| Total investments | $ 1,465 | $ 747 | $ 26 | $ 4,209 | $ 6,447 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 13. Employee Benefit Programs (Continued)

Following is a description of the Plan's valuation methodologies for assets and liabilities measured at fair value. Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources, including market participants, dealers and brokers.

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 Clinic's policy is to recognize transfers in and transfers out as of the actual date of the event or change in circumstances that caused the transfer. There were no significant transfers or activity within investment levels in 2015 or 2014.

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

The following information pertains to those alternative investments recorded at NAV in accordance with the Fair Value Measurements and Disclosures topic of the FASB ASC.

At December 31, 2015, alternative investments recorded at NAV consisted of the following:

| | Fair Value | Unfunded Commitment | Redemption Frequency (If Currently Eligible) | Redemption Notice Period |
|---|---|---|---|---|
| Absolute return/hedge funds (a) | $ 2,633 | $ - | Monthly to annually | 30–90 days |
| Private partnerships (b) | 1,644 | 970 | | |
| | $ 4,277 | $ 970 | | |

At December 31, 2014, alternative investments recorded at NAV consisted of the following:

| | Fair Value | Unfunded Commitment | Redemption Frequency (If Currently Eligible) | Redemption Notice Period |
|---|---|---|---|---|
| Absolute return/hedge funds (a) | $ 2,671 | $ - | Monthly to annually | 30–90 days |
| Private partnerships (b) | 1,538 | 921 | | |
| | $ 4,209 | $ 921 | | |

(a) This category includes investments in absolute return/hedge funds, which are actively managed commingled investment vehicles that derive the majority of their returns from factors other than the directional flow of the markets in which they invest. Representative strategies include high-yield credit, distressed debt, merger arbitrage, relative value, and long-short equity strategies. The fair values of the investments in this category have been estimated using the NAV per share of the investments. Investments in this category generally carry "lockup" restrictions that do not allow investors to seek redemption in the first year after acquisition. Following the initial lockup period, liquidity is generally available monthly, quarterly or annually following a redemption request. Over 90 percent of the investments in this category have at least annual liquidity.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 13. Employee Benefit Programs (Continued)

(b) This category includes limited partnership interests in closed-end funds that focus on venture capital, private equity, real estate and resource-related strategies. The fair values of the investments in this category have been estimated using the NAV of the Plan's ownership interest in partners' capital. These investments cannot be redeemed with the funds. Distributions from each fund will be received as the underlying investments of the funds are liquidated. It is estimated that the underlying assets of most funds will generally be liquidated over a seven- to ten-year period.

No plan assets are expected to be returned to the employer during 2016.

**Other postretirement benefits:**

***Obligations and funded status:*** A summary of the changes in the benefit obligation and plan assets and the resulting funded status of the other postretirement plans is as follows as of and for the years ended December 31:

| | 2015 | 2014 |
|---|---|---|
| Change in projected benefit obligation: | | |
| Benefit obligation at beginning of year | $ 843 | $ 768 |
| Service cost | 12 | 11 |
| Interest cost | 35 | 39 |
| Plan participants' contributions | 21 | 14 |
| Plan change | - | 15 |
| Amendments | 1 | - |
| Medicare subsidy | 2 | 2 |
| Actuarial loss (gain) | (6) | 52 |
| Benefits paid | (67) | (58) |
| Estimated benefit obligation at end of year | $ 841 | $ 843 |
| Change in plan assets: | | |
| Fair value of plan assets at beginning of year | $ - | $ - |
| Employer contributions | 44 | 42 |
| Plan participants' contributions | 21 | 14 |
| Medicare subsidy | 2 | 2 |
| Benefits paid | (67) | (58) |
| Fair value of plan assets at end of year | $ - | $ - |
| Funded status of the plan | $ (841) | $ (843) |

Amounts recognized in the consolidated statements of financial position for postretirement benefits consist of the following at December 31:

| | 2015 | 2014 |
|---|---|---|
| Current liabilities | $ (39) | $ (32) |
| Noncurrent liabilities | (802) | (811) |
| Net amount recognized | $ (841) | $ (843) |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 13. Employee Benefit Programs (Continued)

Components of net periodic benefit cost for other postretirement benefits are as follows for the years ended December 31:

| | 2015 | 2014 |
|---|---|---|
| Service cost | $ 12 | $ 11 |
| Interest cost | 35 | 39 |
| Amortization of: | | |
| Unrecognized prior service benefit | (54) | (59) |
| Unrecognized net actuarial loss | 3 | 3 |
| Net periodic benefit cost for other postretirement benefits | $ (4) | $ (6) |

The Clinic has concluded that the prescription drug benefits under its defined benefit postretirement plan are actuarially equivalent to Medicare Part D under the Medicare Modernization Act (the Act) and that the Clinic will receive the subsidy available under the Act.

The following reflects the expected future Medicare Part D subsidy receipts:

| Years ending December 31: | |
|---|---|
| 2016 | $ 5 |
| 2017 | 5 |
| 2018 | 5 |
| 2019 | 6 |
| 2020 | 6 |
| 2021–2025 | 33 |

A one-percentage-point change in the assumed health care cost trend rate would have the following effects:

| | One-Percentage-Point Increase | One-Percentage-Point Decrease |
|---|---|---|
| Effect on total service and interest cost components in 2015 | $ 2 | $ (2) |
| Effect on postretirement benefit obligation at December 31, 2015 | 39 | (33) |

**Pension and postretirement benefits:**

***Assumptions:*** Weighted-average assumptions used to determine pension and postretirement benefit obligations at the measurement date are as follows:

| | Pension Benefits | | Postretirement Benefits | |
|---|---|---|---|---|
| | 2015 | 2014 | 2015 | 2014 |
| Discount rate | 4.70% | 4.28% | 4.63% | 4.20% |
| Rate of compensation increase | 3.33% | 3.44% | N/A | N/A |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 13. Employee Benefit Programs (Continued)

Weighted-average assumptions used to determine net periodic pension and postretirement benefit cost are as follows:

| | Pension Benefits | | Postretirement Benefits | |
|---|---|---|---|---|
| | 2015 | 2014 | 2015 | 2014 |
| Discount rate | 4.28% | 5.17% | 4.20% | 5.13% |
| Expected long-term return on plan assets | 8.00% | 8.00% | N/A | N/A |
| Rate of compensation increase | 3.31% | 3.52% | N/A | N/A |

The Clinic utilizes a building block approach in determining the expected long-term rate of return for its plan assets. First, historical data on individual asset class returns are studied. Next, the historical correlation among and between asset class returns is studied under both normal conditions and in times of market turbulence. Then, various mixes of asset classes are considered under multiple long-term investment scenarios. Finally, after considering liquidity concerns related to the use of certain alternative asset classes, the plan sponsor selects the portfolio blend that it believes will produce the highest expected long-term return on a risk-adjusted basis.

**Cash flows:**

***Contributions:*** The Clinic expects to contribute $489 to its pension plans in 2016.

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

| | Pension Benefits | | Postretirement |
|---|---|---|---|
| | Qualified | Nonqualified | Benefits |
| Years ending December 31: | | | |
| 2016 | $ 335 | $ - | $ 39 |
| 2017 | 368 | - | 39 |
| 2018 | 404 | - | 40 |
| 2019 | 426 | - | 42 |
| 2020 | 441 | - | 44 |
| 2021–2025 | 2,540 | 1 | 244 |

In addition to the defined benefit plans, the Clinic sponsors various defined contribution benefit plans. Expense recognized by the Clinic for those plans was $83 and $44 for 2015 and 2014, respectively.

### Note 14. General and Professional Liability Insurance

The Clinic insures substantially all general and professional liability risks through a combination of a wholly owned captive insurance company and self-insurance. The insurance program combines various levels of self-insured retention with excess commercial insurance coverage. Actuarial consultants have been retained to assist in the estimation of outstanding general and professional liability loss.

**Notes to Consolidated Financial Statements (In Millions)**

### Note 14. General and Professional Liability Insurance (Continued)

The Clinic's general and professional liability as reported in the accompanying consolidated statements of financial position was $100 and $103 at December 31, 2015 and 2014, respectively. Provisions for the general and professional liability risks are based on an actuarial estimate of losses using the Clinic's actual loss data adjusted for industry trends and current conditions and considering an evaluation of claims by the Clinic's legal counsel. The provision includes estimates of ultimate costs for both reported claims and claims incurred but not reported.

Activity in the liability is summarized as follows for the years ended December 31:

| | 2015 | 2014 |
|---|---|---|
| Balance, beginning of year | $ 103 | $ 113 |
| Incurred related to captive insurance company liability: | | |
| Current year | 22 | 23 |
| Prior years | (15) | (16) |
| Total incurred | 7 | 7 |
| Paid related to captive insurance company liability: | | |
| Current year | - | - |
| Prior years | (7) | (15) |
| Total paid | (7) | (15) |
| Net change in self-insurance liability | (3) | (2) |
| Balance, end of year | $ 100 | $ 103 |

### Note 15. Other Receivables, Other Current and Long-Term Assets, and Other Current and Long-Term Liabilities

At December 31, other receivables consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Pledges receivable | $ 117 | $ 107 |
| Grants receivable | 54 | 48 |
| Other | 102 | 87 |
| | $ 273 | $ 242 |

At December 31, other current assets consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Inventories | $ 121 | $ 114 |
| Prepaid expenses | 45 | 44 |
| Current portion of deferred tax asset | 3 | 2 |
| | $ 169 | $ 160 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 15. Other Receivables, Other Current and Long-Term Assets, and Other Current and Long-Term Liabilities (Continued)

At December 31, other long-term assets consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Pledges receivable | $ 226 | $ 229 |
| Trust receivables | 173 | 185 |
| Oil and gas interests | 50 | 51 |
| Technology-based ventures | 37 | 30 |
| Long-term portion of deferred tax asset | 41 | 42 |
| Other | 106 | 99 |
| | $ 633 | $ 636 |

At December 31, other current liabilities consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Current maturities of long-term debt | $ 49 | $ 50 |
| Current pension and postretirement benefit | 39 | 32 |
| Other taxes | 35 | 31 |
| Short-term disability | 32 | 28 |
| Current portion of professional and general liability | 26 | 26 |
| Real estate tax accrual | 25 | 23 |
| Current portion of long-term disability | 25 | 20 |
| Current portion of workers' compensation liability | 14 | 14 |
| Other | 70 | 97 |
| | $ 315 | $ 321 |

At December 31, other long-term liabilities consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Deferred compensation | $ 421 | $ 400 |
| Long-term disability | 129 | 111 |
| Professional and general liability | 74 | 77 |
| Electronic medical record | 52 | - |
| Trust obligations | 47 | 45 |
| Gift annuities | 46 | 46 |
| Retirement community obligations | 37 | 36 |
| Workers' compensation liability | 28 | 27 |
| Lease agreement liability | 26 | 26 |
| Asset retirement obligation | 25 | 22 |
| Contract deposit | 22 | 22 |
| Other | 59 | 45 |
| | $ 966 | $ 857 |

**Notes to Consolidated Financial Statements (In Millions)**

### Note 16. Other Revenue

For the years ended December 31, other revenue consisted of the following:

| | 2015 | 2014 |
|---|---|---|
| Retail pharmacy sales | $ 281 | $ 251 |
| Royalties | 65 | 52 |
| Technology commercialization, health information, and medical products | 51 | 67 |
| Retail stores | 41 | 20 |
| Cafeteria revenue | 38 | 38 |
| Graduate medical and other education revenue | 31 | 41 |
| Third-party administrative revenue | 18 | 16 |
| Incentive revenue | 18 | 36 |
| Oil- and gas-producing activities | 14 | 24 |
| Other | 164 | 192 |
| | $ 721 | $ 737 |

### Note 17. Commitments and Contingencies

The Clinic has various construction projects and the electronic medical record project discussed below in progress related to patient care, research, and educational facilities. The estimated costs committed to complete the various projects at December 31, 2015, approximated $1,003, all of which is expected to be expended over the next three to five years.

The Clinic has an initiative with a major health care software company to consolidate onto a single, integrated, patient-centered electronic medical record and revenue cycle management platform. The project is highly complex and integral to operations. Operating and capital expenditures are estimated to exceed $1 billion with a project timeline of approximately five years for implementation at all Clinic locations. Successful installation will enhance the Clinic's ability to further standardize patient care and administrative activities that will improve outcomes and experiences for all patients.

One of the Clinic's affiliation agreements limits the involvement of a third party in operations of a consolidated affiliate. A process exists to resolve disputes; however, in the event of an irreconcilable dispute between the parties, the agreement further provides for a one-time payment of approximately $87 by the consolidated affiliate to release the third party from the affiliation. Such payment would be subordinate to other debtors of the consolidated affiliated entity. No amount has been accrued in the consolidated financial statements for this contingency.

While the Clinic is self-insured for a substantial portion of its general and workers' compensation liabilities, the Clinic maintains commercial insurance coverage against catastrophic loss. Additionally, the Clinic maintains a self-insurance program for its long-term disability coverage. The provision for estimated self-insured claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

### Note 17. Commitments and Contingencies (Continued)

Laws and regulations concerning government programs, including Medicare, Medicaid and various research grant programs, are complex and subject to varying interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. As a result of nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. The Clinic expects that the level of review and audit to which it is subject will increase. There can be no assurance that regulatory authorities will not challenge the Clinic's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Clinic.

On November 13, 2015, the Clinic's Board of Trustees resolved to disaffiliate Mayo Clinic Health System—Waycross and return the hospital and related governance to the community directors, ending the integration agreement between Mayo Clinic Jacksonville and Satilla Health Services that created Mayo Clinic Health System—Waycross. Mayo Clinic Health System—Waycross net assets have a book value of $42 at December 31, 2015.

The Clinic is a defendant in various lawsuits arising in the ordinary course of business and records an estimated liability for probable claims. Although the outcome of these lawsuits cannot be predicted with certainty, management believes the ultimate disposition of such matters will not have a material effect on the Clinic's consolidated financial position or statement of activities.

# Supplemental Information

RSM US LLP

## Independent Auditor's Report on the Supplemental Information

Board of Trustees
Mayo Clinic

We have audited the consolidated financial statements of Mayo Clinic and its subsidiaries (the Clinic) as of and for the years ended December 31, 2015 and 2014, and have issued our report thereon, dated February 23, 2016, which contained an unmodified opinion on those consolidated financial statements. Our audits were performed for the purpose of forming an opinion on the consolidated financial statements as a whole.

The accompanying supplemental information is presented for purposes of additional analysis and is not a required part of the consolidated 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 consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits 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 consolidated financial statements, or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

RSM US LLP

Minneapolis, Minnesota
February 23, 2016

## Mayo Clinic

## Consolidating Statement of Financial Position
## December 31, 2015 (In Millions)

| | Mayo Clinic | MFMER * | Florida Hospital | All Other Entities | Eliminations | Total |
|---|---|---|---|---|---|---|
| **Assets** | | | | | | |
| Current assets: | | | | | | |
| Cash and cash equivalents | $ 3 | $ 33 | $ - | $ 17 | $ - | $ 53 |
| Accounts receivable for medical services, less allowances for uncollectible accounts | 307 | 6 | 108 | 1,237 | - | 1,658 |
| Securities lending collateral | 105 | - | - | - | - | 105 |
| Other receivables | 591 | 1,567 | 377 | 1,100 | (3,362) | 273 |
| Other current assets | 17 | 78 | 13 | 61 | - | 169 |
| **Total current assets** | 1,023 | 1,684 | 498 | 2,415 | (3,362) | 2,258 |
| Investments | 4,660 | 320 | - | 2,081 | - | 7,061 |
| Investments under securities lending agreement | 111 | - | - | - | - | 111 |
| Other long-term assets | 630 | 54 | - | 276 | (327) | 633 |
| Property, plant and equipment, net | 1,231 | 228 | 240 | 2,531 | - | 4,230 |
| **Total assets** | $ 7,655 | $ 2,286 | $ 738 | $ 7,303 | $ (3,689) | $ 14,293 |
| **Liabilities and Net Assets** | | | | | | |
| Current liabilities: | | | | | | |
| Accounts payable | $ 37 | $ 279 | $ 5 | $ 78 | $ - | $ 399 |
| Accrued payroll | 166 | 326 | 4 | 121 | - | 617 |
| Accrued employee benefits | 133 | - | - | - | - | 133 |
| Deferred revenue | 16 | 12 | - | 12 | - | 40 |
| Long-term variable-rate debt | 360 | - | - | - | - | 360 |
| Securities lending payable | 105 | - | - | - | - | 105 |
| Other current liabilities | 1,256 | 1,245 | 113 | 1,062 | (3,361) | 315 |
| **Total current liabilities** | 2,073 | 1,862 | 122 | 1,273 | (3,361) | 1,969 |
| Long-term debt | 1,948 | - | 126 | 314 | - | 2,388 |
| Accrued pension and postretirement benefits, net of current | 1,272 | - | - | 51 | - | 1,323 |
| Other long-term liabilities | 409 | 224 | 52 | 465 | (184) | 966 |
| **Total liabilities** | 5,702 | 2,086 | 300 | 2,103 | (3,545) | 6,646 |
| Net assets: | | | | | | |
| Unrestricted | (120) | 194 | 438 | 4,794 | (144) | 5,162 |
| Temporarily restricted | 1,136 | 4 | - | 179 | - | 1,319 |
| Permanently restricted | 937 | 2 | - | 227 | - | 1,166 |
| **Total net assets** | 1,953 | 200 | 438 | 5,200 | (144) | 7,647 |
| **Total liabilities and net assets** | $ 7,655 | $ 2,286 | $ 738 | $ 7,303 | $ (3,689) | $ 14,293 |

*Mayo Foundation for Medical Education and Research (MFMER)

## Mayo Clinic

## Consolidating Statement of Financial Position
## December 31, 2014 (In Millions)

| | Mayo Clinic | MFMER * | Florida Hospital | All Other Entities | Eliminations | Total |
|---|---|---|---|---|---|---|
| **Assets** | | | | | | |
| Current assets: | | | | | | |
| Cash and cash equivalents | $ 4 | $ 17 | $ - | $ 34 | $ - | $ 55 |
| Accounts receivable for medical services, less allowances for uncollectible accounts | 288 | 4 | 98 | 1,105 | - | 1,495 |
| Securities lending collateral | 85 | - | - | - | - | 85 |
| Other receivables | 565 | 944 | 250 | 1,172 | (2,689) | 242 |
| Other current assets | 11 | 65 | 12 | 72 | - | 160 |
| **Total current assets** | 953 | 1,030 | 360 | 2,383 | (2,689) | 2,037 |
| Investments | 4,732 | 615 | - | 1,832 | - | 7,179 |
| Investments under securities lending agreement | 91 | - | - | - | - | 91 |
| Other long-term assets | 582 | 58 | - | 278 | (282) | 636 |
| Property, plant and equipment, net | 1,373 | 144 | 245 | 2,295 | - | 4,057 |
| **Total assets** | $ 7,731 | $ 1,847 | $ 605 | $ 6,788 | $ (2,971) | $ 14,000 |
| **Liabilities and Net Assets** | | | | | | |
| Current liabilities: | | | | | | |
| Accounts payable | $ 61 | $ 219 | $ 4 | $ 127 | $ - | $ 411 |
| Accrued payroll | 140 | 262 | 3 | 150 | - | 555 |
| Accrued employee benefits | 128 | - | - | - | - | 128 |
| Deferred revenue | 22 | 12 | - | 9 | - | 43 |
| Long-term variable-rate debt | 360 | - | - | - | - | 360 |
| Securities lending payable | 85 | - | - | - | - | 85 |
| Other current liabilities | 1,153 | 951 | 95 | 811 | (2,689) | 321 |
| **Total current liabilities** | 1,949 | 1,444 | 102 | 1,097 | (2,689) | 1,903 |
| Long-term debt | 1,989 | - | 127 | 321 | - | 2,437 |
| Accrued pension and postretirement benefits, net of current | 1,507 | - | - | 104 | - | 1,611 |
| Other long-term liabilities | 343 | 204 | 3 | 445 | (138) | 857 |
| **Total liabilities** | 5,788 | 1,648 | 232 | 1,967 | (2,827) | 6,808 |
| Net assets: | | | | | | |
| Unrestricted | (103) | 191 | 373 | 4,444 | (144) | 4,761 |
| Temporarily restricted | 1,148 | 5 | - | 170 | - | 1,323 |
| Permanently restricted | 898 | 3 | - | 207 | - | 1,108 |
| **Total net assets** | 1,943 | 199 | 373 | 4,821 | (144) | 7,192 |
| **Total liabilities and net assets** | $ 7,731 | $ 1,847 | $ 605 | $ 6,788 | $ (2,971) | $ 14,000 |

*Mayo Foundation for Medical Education and Research (MFMER)

**Mayo Clinic**

## Consolidating Statement of Activities
## Year Ended December 31, 2015 (In Millions)

| | Mayo Clinic | MFMER * | Florida Hospital | All Other Entities | Eliminations | Total |
|---|---|---|---|---|---|---|
| Revenue, gains and other support: | | | | | | |
| Net medical service revenue | $ 2,015 | $ 40 | $ 460 | $ 6,118 | $ (13) | $ 8,620 |
| Grants and contracts | 319 | - | - | 67 | - | 386 |
| Investment return allocated to current activities | 232 | - | - | 1 | - | 233 |
| Contributions available for current activities | 177 | - | - | 34 | - | 211 |
| Premium revenue | - | - | - | 144 | - | 144 |
| Other | 444 | 329 | 10 | 340 | (402) | 721 |
| Net assets released from restrictions | - | - | - | - | - | - |
| **Total revenue, gains and other support** | 3,187 | 369 | 470 | 6,704 | (415) | 10,315 |
| Expenses: | | | | | | |
| Salaries and benefits | 2,234 | 770 | 108 | 3,278 | (19) | 6,371 |
| Supplies and services | 834 | (525) | 259 | 2,447 | (394) | 2,621 |
| Facilities | 227 | 106 | 29 | 337 | (2) | 697 |
| Finance and investment | 69 | 13 | 9 | 9 | - | 100 |
| **Total expenses** | 3,364 | 364 | 405 | 6,071 | (415) | 9,789 |
| **Income (loss) from current activities** | (177) | 5 | 65 | 633 | - | 526 |
| Noncurrent and other items: | | | | | | |
| Contributions not available for current activities, net | 69 | - | - | (9) | - | 60 |
| Unallocated investment (loss) return, net | (128) | 6 | - | 11 | - | (111) |
| Income tax expense | (2) | (5) | - | (26) | - | (33) |
| Reclassifications and other | 2 | - | - | (1) | - | 1 |
| **Total noncurrent and other items** | (59) | 1 | - | (25) | - | (83) |
| **Increase (decrease) in net assets before other changes in net assets** | (236) | 6 | 65 | 608 | - | 443 |
| Pension and other postretirement benefit adjustments | (48) | - | - | 60 | - | 12 |
| Transfer from (to) related organizations | 294 | (5) | - | (289) | - | - |
| **Increase in net assets** | 10 | 1 | 65 | 379 | - | 455 |
| Net assets at beginning of year | 1,943 | 199 | 373 | 4,821 | (144) | 7,192 |
| Net assets at end of year | $ 1,953 | $ 200 | $ 438 | $ 5,200 | $ (144) | $ 7,647 |

*Mayo Foundation for Medical Education and Research (MFMER)

**Mayo Clinic**

## Consolidating Statement of Activities
## Year Ended December 31, 2014 (In Millions)

| | Mayo Clinic | MFMER * | Florida Hospital | All Other Entities | Eliminations | Total |
|---|---|---|---|---|---|---|
| Revenue, gains and other support: | | | | | | |
| Net medical service revenue | $ 2,026 | $ 35 | $ 435 | $ 5,676 | $ (7) | $ 8,165 |
| Grants and contracts | 318 | - | - | 57 | - | 375 |
| Investment return allocated to current activities | 172 | - | - | 1 | - | 173 |
| Contributions available for current activities | 150 | - | - | 29 | - | 179 |
| Premium revenue | - | - | - | 132 | - | 132 |
| Other | 440 | 338 | 10 | 339 | (390) | 737 |
| Net assets released from restrictions | - | - | - | - | - | - |
| **Total revenue, gains and other support** | 3,106 | 373 | 445 | 6,234 | (397) | 9,761 |
| Expenses: | | | | | | |
| Salaries and benefits | 2,123 | 626 | 102 | 3,041 | (20) | 5,872 |
| Supplies and services | 701 | (411) | 235 | 2,140 | (375) | 2,290 |
| Facilities | 223 | 103 | 29 | 316 | (2) | 669 |
| Finance and investment | 71 | 12 | 6 | 7 | - | 96 |
| **Total expenses** | 3,118 | 330 | 372 | 5,504 | (397) | 8,927 |
| **Income (loss) from current activities** | (12) | 43 | 73 | 730 | - | 834 |
| Noncurrent and other items: | | | | | | |
| Contributions not available for current activities, net | 108 | - | - | (10) | - | 98 |
| Unallocated investment (loss) return, net | 189 | (1) | - | 42 | - | 230 |
| Income tax expense | (2) | (2) | - | (28) | - | (32) |
| Reclassifications and other | (3) | (2) | - | 3 | - | (2) |
| **Total noncurrent and other items** | 292 | (5) | - | 7 | - | 294 |
| **Increase in net assets before other changes in net assets** | 280 | 38 | 73 | 737 | - | 1,128 |
| Pension and other postretirement benefit adjustments | (1,468) | - | - | (122) | - | (1,590) |
| Transfer from (to) related organizations | 63 | (5) | - | (58) | - | - |
| **Increase (decrease) in net assets** | (1,125) | 33 | 73 | 557 | - | (462) |
| Net assets at beginning of year | 3,068 | 166 | 300 | 4,264 | (144) | 7,654 |
| Net assets at end of year | $ 1,943 | $ 199 | $ 373 | $ 4,821 | $ (144) | $ 7,192 |

*Mayo Foundation for Medical Education and Research (MFMER)

# APPENDIX C

## Summary of Certain Provisions of the Indenture

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## APPENDIX C

## SUMMARY OF CERTAIN PROVISIONS OF THE INDENTURE

The following is a summary of certain provisions of the Indenture that are not described elsewhere in this Offering Memorandum. The Bonds are issued and secured pursuant to the Indenture. References to the Indenture or a fund or account refer to the related document, fund or account with respect to the Bonds, as described in the Offering Memorandum. Unless otherwise specified to the contrary in this Appendix D, all definitions and provisions summarized refer to the Indenture. This summary does not purport to be comprehensive and reference should be made to the Indenture for a full and complete statement of its provisions.

**Definitions**

Unless the context otherwise requires, the following terms shall have the meanings specified below.

*"Act of Bankruptcy"* means any of the following events:

(a) any Obligated Party shall (i) apply for or consent to the appointment of or the taking of possession by a trustee, receiver, custodian, liquidator or the like of any Obligated Party or all or a substantial part of its property, (ii) commence a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect) or (iii) file a petition with respect to itself seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts; or

(b) A proceeding or case shall be commenced, without the application or consent of an Obligated Party, in any court of competent jurisdiction, seeking (i) the liquidation, reorganization, dissolution, winding-up or composition or adjustment of debts of such Obligated Party, (ii) the appointment of a trustee, receiver, custodian, liquidator or the like of such Obligated Party or of all or a substantial part of its property or (iii) similar relief in respect of any Obligated Party under any law relating to bankruptcy, insolvency, reorganization, winding-up or composition or adjustment of debts, and such proceeding or case shall not be dismissed within 60 days after the commencement thereof.

*"Affiliate"* means any entity which is a member of the same controlled group (within the meaning of Section 1.150-1(e) of the Treasury Regulations) as the Clinic.

"*Authorized Denomination*" means $1,000 or any integral multiple thereof.

"*Authorized Representative*" means the Clinic's President, Vice President, Chief Financial Officer, Secretary, Treasurer, Investment Officer, Assistant Secretary or Assistant Treasurer, or any other Person designated as an Authorized Representative of the Clinic by a Certificate of the Clinic signed by the Clinic's Vice President for Finance and Treasurer or Assistant Treasurer, and filed with the Trustee.

"*Beneficial Owner*" means any Person which has or shares the power, directly or indirectly, to make investment decisions concerning ownership of any of the Bonds (including

any Person holding Bonds through nominees, depositories or other intermediaries) established to the reasonable satisfaction of the Trustee or the Clinic.

"*Bond Fund*" means the fund by that name established pursuant to the Indenture.

"*Bond Purchase Agreement*" means the Bond Purchase Agreement dated [_____], 2016, between the Clinic and the Underwriters.

"*Bonds*" means the Mayo Clinic __% Taxable Bonds, Series 2016 authorized by, and at any time Outstanding pursuant to, the Indenture.

"*Book-Entry Form*" or "*Book-Entry System*" means a form or system, as applicable, under which physical bond certificates in fully registered form are registered only in the name of a Securities Depository or its nominee as Bondholder, with the physical bond certificates held by and "immobilized" in the custody of the Securities Depository and the book-entry system maintained by and the responsibility of others than the Clinic or the Trustee is the record that identifies and records the transfer of the interests of the owners of book-entry interests in those Bonds.

"*Business Day*" means any day other than (A) a Saturday or Sunday or legal holiday or a day on which banking institutions in the city or cities in which the Designated Office of the Trustee is located are authorized by law or executive order to close or (B) a day on which the New York Stock Exchange is closed.

*"Capitalized Lease"* means a lease of Property which is capitalized on the financial statements of the lessee.

*"Capitalized Rentals"* means the aggregate amount of Net Rentals due and to become due under a Capitalized Lease reflected as a liability on the balance sheet of the lessee.

"'*Certificate'*, '*Statement'*, '*Request'* or '*Requisition' of the Clinic*" means, respectively, a written certificate, statement, request or requisition signed in the name of the Clinic by an Authorized Representative. Any such instrument and supporting opinions or representations, if any, may, but need not, be combined in a single instrument with any other instrument, opinion or representation, and the two or more so combined shall be read and construed as a single instrument. If and to the extent required by the Indenture, each such instrument shall include the statements provided for in the Indenture.

"*Clinic*" means Mayo Clinic, a Minnesota nonprofit corporation, or said nonprofit corporation's successor or successors.

"*Code*" means the Internal Revenue Code of 1986, as amended, or any successor statute thereto and any regulations promulgated thereunder.

*"Controlled Affiliate"* means any Affiliate which is controlled, directly or indirectly, by the Clinic by reason of the Clinic's status as the controlling member (in the case of nonprofit Affiliates) or controlling shareholder (in the case of for profit Affiliates) of such Affiliate.

*"Covered Indebtedness"* means all or that portion of the principal of, premium, if any, or interest on Indebtedness with respect to which a Pass-Through Obligation provides for payment thereof.

"*Default*" means any event which is or after notice or lapse of time or both would become an Event of Default.

"*Designated Office*" means the Designated Office of the Trustee, which as of the date of the Indenture is located at 625 Marquette Avenue, MAC N9311-115, Minneapolis, Minnesota, 55479 Attention: Corporate Trust, and such other offices as the Trustee may designate from time to time by written notice to the Clinic and the Holders.

"*Event of Default*" means any of the events specified as such in the Indenture.

*"Government Obligations"* means (i) direct obligations of the United States of America for the payment of which the full faith and credit of the United States of America is pledged, and (ii) obligations issued by a person controlled or supervised by and acting as an instrumentality of the United States of America, the payment of the principal of premium, if any, and interest on which is fully guaranteed as a full faith and credit obligation of the United States of America (including any securities described in (i) or (ii) issued or held in book-entry form on the books of the Department of the Treasury of the United States of America or Federal Reserve Bank).

*"Guaranty"* means an obligation of the Clinic guaranteeing in any manner an obligation of a Third Party which would constitute Indebtedness if such guaranteed obligation were the obligation of the Clinic.

"*Holder*" or "*Bondholder*", whenever used in the Indenture with respect to a Bond, means the Person in whose name such Bond is registered.

*"Indebtedness"* means all obligations for borrowed money, all installment purchase and similar obligations, all Guaranties and all Capitalized Rentals incurred, assumed or guaranteed, but excluding (a) any obligation for which there has been established an escrow or similar fund or account for the payment in full of such obligation when due, (b) any obligation incurred, assumed or guaranteed for the payment of other Outstanding Indebtedness, to the extent that, until the date of payment of such other Indebtedness, the debt service on such obligation is payable from an escrow or similar fund or account established from the proceeds of such obligation, (c) accounts payable, trade accounts or accrued expenses or liabilities incurred, assumed or guaranteed in the ordinary course of business, (d) any obligation incurred, assumed or guaranteed under or in connection with a letter of credit, line of credit, surety bond, bond insurance or other credit enhancement obtained to secure any other Indebtedness and under which a payment, borrowing or drawing has not been made or such obligation has not otherwise become a direct or non-contingent obligation, (e) any Guaranty with respect to which a payment has not been made during the twelve-month period immediately preceding the date the calculation is made, (f) any Non-Recourse Indebtedness, and (g) any Covered Indebtedness with respect to which all payments under the related Pass-Through Obligation have been made when due during the twelve-month period immediately preceding the date the calculation is made.

"*Indenture*" means the Indenture of Trust, by and between the Clinic and the Trustee, as originally executed or as it may from time to time be supplemented, modified or amended by any Supplemental Indenture.

"*Indenture Fund*" means the fund by that name established pursuant to the Indenture.

"*Interest Account*" means the account by that name in the Bond Fund established pursuant to the Indenture.

"*Interest Payment Date*" means May 15 and November 15 of each year, commencing November 15, 2016.

"*Investment Securities*" means any of the following:

(1) Government Obligations and other United States agency obligations guaranteed by the full faith and credit of the United States of America;

(2) shares in any investment company registered under the federal Investment Company Act of 1940 whose shares are registered under the federal Securities Act of 1933 and the majority of whose investments in principal amount (valued on a cost basis) are investments described in subsections (1), (3), (4), (5), (6) or (7), including specifically the Metropolitan West Low Duration Bond Fund;

(3) certificates of deposit, time deposits, bankers acceptances or money market savings accounts denominated in dollars and issued or offered by any bank, savings institution or trust company, including the Trustee, having combined capital and surplus of at least $25,000,000 and whose deposits are insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation, or issued by a foreign subsidiary of any national banking association or any bank or trust company incorporated under any state in the United States of America or the District of Columbia having combined capital and surplus of at least $25,000,000, or issued by a bank or trust company whose securities or obligations (or the securities or obligations of the parent corporation of such bank or trust company) are rated by each Rating Agency then having an outstanding rating on the Bonds in one of its highest four Rating Categories;

(4) corporate debt including bonds, notes, debentures and secured mortgage debt, provided that the debt is rated in one of the four highest Rating Categories by either Rating Agency;

(5) written, overnight repurchase agreements with any bank, savings institution or trust company, including the Trustee, having combined capital and surplus of at least $25,000,000 and whose deposits are insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation, or with any broker dealer which is a member of the Securities Investors Protection Corporation, provided in any case that such repurchase agreements are fully secured in an amount equal to at least 102% of the principal thereof by Government Obligations which are delivered to and held in the possession of the Trustee or its designee and in which the Trustee has a first perfected security interest free and clear of any third party claims;

(6) obligations described in Section 103(a) of the Code which are rated by each Rating Agency then having an outstanding rating on the Bonds in one of its highest four Rating Categories;

(7) mortgage and other asset-backed securities issued by either agency or non-agency entities of the United States;

(8) guaranteed investment contracts with insurance companies with a claims paying rating from a Rating Agency at the time the contract or agreement is made at least equal to the rating of the Bonds, or with other financial institutions or corporations, provided that, at the time the contract or agreement is made, the debt obligations of such financial institution or corporation are rated by each Rating Agency then having a rating on the Bonds in one of the four highest Rating Categories or

(9) notes, bonds, debentures or other debt issued by domestic corporations, provided that, at the time of purchase, such obligations are rated by each Rating Agency then having a rating on the Bonds in one of its four highest Rating Categories.

*"Lien"* means any mortgage or pledge of, security interest in or lien, charge or other encumbrance on any Property (other than a Pass-Through Obligation) which secures any obligation or otherwise grants a right to a Third Party.

"*Moody's*" means Moody's Investors Service, a corporation organized and existing under the laws of the State of Delaware, its successors and their assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Clinic upon notice to the Trustee.

*"Net Rentals"* means all fixed rents (including all payments which the lessee is obligated to make to the lessor on termination of the lease or surrender of the Property, other than upon termination of the lease for a default thereunder) payable under a lease or sublease of Property, excluding any amounts required to be paid by the lessee (whether or not designated as rents or additional rents) on account of maintenance, repairs, insurance, taxes and similar charges.

*"Non-Recourse Indebtedness"* means Indebtedness secured by a Lien, liability for which is effectively limited to the Property purchased or otherwise acquired with the proceeds of such Indebtedness without recourse, directly or indirectly, to any other Property.

*"Obligated Party"* means, initially, the Clinic, and thereafter any Affiliate that becomes an Obligated Party pursuant to the Indenture.

"*Offering Memorandum*" means the final offering memorandum dated [_____], 2016, relating to the Bonds.

"*Opinion of Counsel*" means a written opinion of counsel (who may be counsel for the Clinic, but not an employee thereof) satisfactory to the Trustee.

"*Outstanding*" when used as of any particular time with reference to Bonds, means (subject to the provisions of the Indenture) all Bonds theretofore, or thereupon being, authenticated and delivered by the Trustee under the Indenture except (1) Bonds theretofore cancelled by the Trustee or surrendered to the Trustee for cancellation; (2) Bonds with respect to which all liability of the Clinic shall have been discharged in accordance with the Indenture; and (3) Bonds for the transfer or exchange of or in lieu of or in substitution for which other Bonds shall have been authenticated and delivered by the Trustee pursuant to the Indenture.

*"Parent Corporation"* means the Clinic or any corporation which becomes the Parent Corporation under the Indenture.

*"Pass-Through Obligation"* means an unconditional obligation of a Third Party to make payments to the Clinic under a loan, lease, installment sale or similar agreement; provided that (a) the amount lent to such Third Party was derived from or the Property subject to such lease, installment sale or similar agreement was financed or refinanced with the proceeds of Indebtedness incurred by the Clinic, (b) the payments to be made by such Third Party under such agreement (to the extent that such payments relate to debt service on such Indebtedness) are at least equal in amount to the require debt service payments on such Indebtedness and are payable at or before the time debt service payments are required to be made by the Clinic on such Indebtedness and (c) with the consent of such Third Party, such agreement has been assigned and pledged by the Clinic to the holder of such Covered Indebtedness or to a trustee therefor and such agreement provides that payments thereunder (or the portion thereof relating to debt service on such Covered Indebtedness) are, either unconditionally or in the event of a default under the related Covered Indebtedness, to be made directly to such holder or trustee.

"*Payment Date*" means an Interest Payment Date or a Principal Payment Date.

*"Permitted Encumbrances"* means:

(a) Liens and charges incident to construction or maintenance now or hereafter filed of record which are being contested in good faith and which have not proceeded to final judgment (and for which all applicable periods for appeal or review have not expired);

(b) notices of lis pendens or other notices of pending actions which are being contested in good faith and which have not proceeded to final judgment (and for which all applicable periods for appeal or review have not expired);

(c) the lien of taxes and assessments which are not delinquent or which are being contested in good faith;

(d) minor defects and irregularities in title which in the aggregate do not materially and adversely affect the value or operation of Property for the purposes for which such Property is or may reasonably be expected to be used;

(e) easements, exceptions or reservations for the purpose of pipelines, telephone lines, telegraph lines, power lines and substations, roads, streets, alleys, highways, railroad purposes, drainage and sewerage purposes, dikes, canals, laterals, ditches, the removal of oil, gas, coal or other minerals and other like purposes or for the joint or common use of real

property, facilities and equipment, which in the aggregate do not materially and adversely affect the value or operation of Property for the purposes for which such Property is or may reasonably be expected to be used;

(f) rights reserved to or vested in any municipality or governmental or other public authority to control, regulate or use in any manner any portion of Property which in the aggregate do not materially and adversely affect the value or operation of such Property for the purposes for which such Property is or may reasonably be expected to be used;

(g) zoning laws and ordinances;

(h) Liens securing Indebtedness for the payment, redemption or satisfaction of which moneys or evidences of Indebtedness in the necessary amount have been deposited in trust with a trustee or other holder of such Indebtedness; the pledge of any reserve fund or other fund established to secure the repayment of Indebtedness; any pledge of or security in a self insurance reserve fund; Liens securing Non-Recourse Indebtedness; and the pledge of receivables to secure any financing thereof;

(i) purchase money security interests and security interests existing on Property prior to the time of its acquisition through purchase, merger, consolidation or otherwise, whether or not assumed by the purchaser thereof, or placed upon Property being acquired to secure a portion of the purchase price thereof, or Liens on Property incurred in connection with construction financing for such Property or lessor's interests in Capitalized Leases (other than with respect to sale and leaseback transactions); provided that, unless such Property was acquired through merger, consolidation or assumption of debt, the aggregate principal amounts secured by any such interests shall not exceed at the time of incurrence the fair market value of the Property so encumbered;

(j) statutory Liens arising in the ordinary course of business which are not delinquent or which are being contested in good faith;

(k) the lease or license of the use of Property for use in performing professional or other services necessary for the proper and economical operation of such Property;

(l) all leases, purchase contracts and security interests existing on the date of the Indenture; and

(m) Liens securing Indebtedness if, at the time of incurrence of such Indebtedness, the principal amount of such Indebtedness, together with the aggregate of all other secured Indebtedness of the Clinic and its consolidated Affiliates (excluding Indebtedness described in clauses (h), (i) and (1) of this definition) and all Indebtedness of the Clinic with respect to sale and leaseback transactions, does not exceed 5% of the consolidated net assets of the Clinic and its consolidated Affiliates.

*"Person"* means any natural person, firm, corporation, partnership, association, governmental entity or other entity.

"*Principal Account*" means the account by that name in the Bond Fund established pursuant to the Indenture.

"*Principal Payment Date*" means November 15, 20[__], the date of final maturity of the Bonds.

"*Project*" means eligible corporate purposes of the Clinic.

*"Property"* means any and all right, title and interest of a Person in and to any and all property, whether real or personal, tangible or intangible and wherever situated, including cash.

"*Rating Agency*" means Moody's and S&P.

"*Rating Category*" means a generic securities rating category, without regard to any refinement or gradation of such rating category by a numerical modifier or otherwise.

"*Record Date*" means the first (1st) day (whether or not a Business Day) of the month in which each Interest Payment Date occurs.

"*Redemption Fund*" means the fund by that name established pursuant to the Indenture.

*"Redemption Price"* means, in the case of optional redemption, the greater of (1) 100% of the principal amount of the Bonds to be redeemed; and (2) the sum of the present value of the remaining scheduled payments of principal and interest to the maturity date of the Bonds to be redeemed, not including any portion of those payments of interest accrued and unpaid as of the date on which the Bonds are to be redeemed, discounted to the date on which the Bonds are to be redeemed on a semi-annual basis assuming a 360-day year consisting of twelve 30-day months at the adjusted Treasury Rate plus __ basis points, plus, in each case, accrued and unpaid interest on the Bonds to be redeemed on the redemption date, all as calculated by the Clinic.

"*Responsible Officer*" means any officer of the Trustee assigned to administer its duties under the Indenture.

"*S&P*" means Standard & Poor's, a division of The McGraw-Hill Companies, a corporation organized and existing under the laws of the State of New York, its successors and their assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating agency, any other nationally recognized securities rating agency designated by the Clinic upon notice to the Trustee.

"*Securities Depository*" means The Depository Trust Company and its successors and assigns, or any other securities depository selected as set forth in the Indenture, which agrees to follow the procedures required to be followed by such securities depository in connection with the Bonds.

"*Special Record Date*" means the date established by the Trustee pursuant to the Indenture as the record date for the payment of defaulted interest on the Bonds.

*"State"* means the State of Minnesota.

"*Supplemental Indenture*" means any indenture hereafter duly authorized and entered into between the Clinic and the Trustee, supplementing, modifying or amending the Indenture; but only if and to the extent that such Supplemental Indenture is specifically authorized under the Indenture.

*"Tax Exempt Organization"* means any organization described in Section 501(c)(3) of the Code, which is exempt from federal income tax under Section 501(a) of the Code.

*"Third Party"* means any Person other than the Clinic or its Affiliates.

"*Treasury Rate*" means, as of any redemption date, the yield to maturity as of such redemption date of United States Treasury securities with a constant maturity (as compiled and published in the most recent Federal Reserve Statistical Release H.15 (519) that has become publicly available at least two Business Days prior to the redemption date (excluding inflation indexed securities) (or, if such Statistical Release is no longer published, any publicly available source of similar market data)) most nearly equal to the period from the redemption date to the maturity date of the Bond to be redeemed; provided, however, that if the period from the redemption date to such maturity date is less than one year, the weekly average yield on actually traded United States Treasury securities adjusted to a constant maturity of one year will be used.

"*Trustee*" means Wells Fargo Bank, National Association, a national banking association, with its designated corporate office in Minneapolis, Minnesota, or its successor or successors, as Trustee under the Indenture as provided in the Indenture.

"*Underwriters*" means Merrill Lynch, Pierce, Fenner & Smith Incorporated and Wells Fargo Bank, National Association.

"*Uniform Commercial Code*" means the Uniform Commercial Code as in effect in the State from time to time.

**Establishment and Pledge of Indenture Fund**

Subject only to the provisions of the Indenture permitting or requiring the application thereof for the purposes and on the terms and conditions set forth therein, the Indenture Fund and all amounts held therein are pledged, assigned and transferred by the Clinic to the Trustee for the benefit of the Bondholders to secure the full payment of the principal or Redemption Price of and interest on the Bonds in accordance with their terms and the provisions of the Indenture. The Clinic grants to the Trustee a security interest in and acknowledges and agrees that the Indenture Fund and all amounts on deposit therein shall constitute collateral security to secure the full payment of the principal or Redemption Price of and interest on the Bonds in accordance with their terms and the provisions of the Indenture. For purposes of creating, perfecting and maintaining the security interest of the Trustee on behalf of the Bondholders in and to the Indenture Fund and all amounts on deposit therein, the parties to the Indenture agree as follows: (1) the Indenture shall constitute a "security agreement" for purposes of the Uniform Commercial Code; (2) the Trustee shall maintain on its books records reflecting the interest, as set forth in the Indenture, of the Bondholders in the Indenture Fund and/or the amounts on deposit therein; and (3) the Indenture Fund and the amounts on deposit therein and any proceeds thereof shall be held by the Trustee acting in its capacity as an agent of the Bondholders, and the

holding of such items by the Trustee (including the transfer of any items among the funds and accounts in the Indenture Fund) is deemed possession of such items on behalf of the Bondholders.

Nothing in the Indenture or in the Bonds, expressed or implied, shall be construed to constitute a security interest under the Uniform Commercial Code or otherwise in the assets of the Clinic other than in any interest of the Clinic in the Indenture Fund and/or the amounts on deposit therein. No recourse for the payment of the principal or Redemption Price of or interest on any Bond, or for any claim based thereon or otherwise in respect thereof, and no recourse under or upon any obligation, covenant or agreement of the Clinic in the Indenture or in any Supplemental Indenture or in any Bond, or because of the creation of any indebtedness represented thereby, shall be had against any employee, agent, or officer, as such, past, present or future, of the Clinic or of any successor entity, either directly or through any successor entity, whether by virtue of any constitution, statute or rule of law, or by the enforcement of any assessment or penalty or otherwise, it being expressly understood that all such liability is expressly waived and released as a condition of, and as a consideration for, the execution of the Indenture and the issue of the Bonds. No officer or agent of the Clinic, nor any Person executing the Bonds, shall in any event be subject to any personal liability or accountability by reason of the issuance of the Bonds.

**Funds and Accounts**

The Indenture creates an Indenture Fund (and a Bond Fund and a Redemption Fund thereunder). The Indenture also creates an Interest Account and Principal Account under the Bond Fund. All of the funds and accounts are to be held by the Trustee.

*Application of Proceeds of Bonds*. The proceeds of the Bonds will be used by the Clinic for eligible corporate purposes.

*Indenture Fund*. The Trustee establishes for the sole benefit of the Bondholders, a trust fund referred to in the Indenture as the "Indenture Fund" containing the Bond Fund and the Redemption Fund, and each of the accounts contained therein. The Indenture Fund and each of the funds and accounts in the Indenture Fund shall be identified on the books of the Trustee and shall be maintained by the Trustee and held in trust apart from all other moneys and securities held under the Indenture or otherwise, and the Trustee shall have the exclusive and sole right of withdrawal therefrom in accordance with the terms of the Indenture. All amounts deposited with the Trustee pursuant to the Indenture shall be held, disbursed, allocated and applied by the Trustee only as provided in the Indenture.

*Bond Fund*. Upon the receipt thereof, the Trustee shall deposit all payments received from the Clinic (other than amounts which are to be deposited in the Redemption Fund or income or profit from investments which are to be applied pursuant to the Indenture) in a special fund designated the "Bond Fund" which the Trustee shall establish and maintain and hold in trust and which shall be disbursed and applied only as authorized in the Indenture.

At the times specified below, the Trustee shall allocate within the Bond Fund in the following order of priority the following amounts to the following accounts or funds, each of

which the Trustee shall establish and maintain and hold in trust and each of which shall be disbursed and applied only as authorized in the Indenture: (1) on each Interest Payment Date, the Trustee shall deposit in the "Interest Account" the aggregate amount of interest becoming due and payable on such Interest Payment Date on all Bonds then Outstanding, until the balance in said account is equal to said aggregate amount of interest; and (2) on each Principal Payment Date, the Trustee shall deposit in the "Principal Account" the aggregate amount of principal becoming due and payable on such Principal Payment Date, until the balance in said account is equal to said aggregate amount of such principal.

*Interest Account*. All amounts in the Interest Account shall be used and withdrawn by the Trustee solely for the purpose of paying interest on the Bonds as it shall become due and payable (including accrued interest on any Bonds redeemed prior to maturity pursuant to the Indenture).

*Principal Account*. All amounts in the Principal Account shall be used and withdrawn by the Trustee solely to pay the principal of the Bonds at maturity.

*Redemption Fund*. Upon the receipt thereof, the Trustee shall deposit the following amounts in a special fund designated the "Redemption Fund" which the Trustee shall establish and maintain and hold in trust all moneys deposited by the Clinic with the Trustee directed to be deposited in the Redemption Fund.

All amounts deposited in the Redemption Fund shall be used and withdrawn by the Trustee solely for the purpose of redeeming Bonds, in the manner and upon the terms and conditions specified in the Indenture, at the next succeeding date of redemption for which notice has been given; provided that, at any time prior to the selection of Bonds for such redemption, the Trustee shall, upon direction of the Clinic, apply such amounts to the purchase of Bonds at public or private sale, as and when and at such prices (including brokerage and other charges, but excluding accrued interest, which is payable from the Interest Account) as the Clinic may direct, except that the purchase price (exclusive of accrued interest) may not exceed the Redemption Price then applicable to such Bonds (or, if such Bonds are not then subject to redemption, the par value of such Bonds); and provided further that in lieu of redemption at such next succeeding date of redemption, or in combination therewith, amounts in such account may be transferred to the Principal Account as set forth in a Request of the Clinic.

*Payments by the Clinic; Allocation of Funds*. On or before each Payment Date, until the principal of and interest on, the Bonds shall have been fully paid or provision for such payment shall have been made as provided in the Indenture, the Clinic shall pay to the Trustee a sum equal to the amount payable on such Payment Date as principal of and interest on the Bonds. Each payment made pursuant to this paragraph shall at all times be sufficient to pay the total amount of interest and principal (whether at maturity or upon acceleration) becoming due and payable on the Bonds on such Payment Date. If on any Payment Date the amounts held by the Trustee in the accounts within the Bond Fund are insufficient to make any required payments of principal of (whether at maturity or upon acceleration) and interest on the Bonds as such payments become due, the Clinic shall forthwith pay such deficiency to the Trustee.

The obligations of the Clinic to make the payments required by the immediately preceding paragraph and to perform and observe the other agreements on its part contained in the

Indenture shall be a general obligation of the Clinic, absolute and unconditional, irrespective of any defense or any rights of set-off, recoupment or counterclaim it might otherwise have against the Trustee, and during the term of the Indenture, the Clinic shall pay all payments required to be made by the immediately preceding paragraph (which payments shall be net of any other obligations of the Clinic) as prescribed therein and all other payments required under the Indenture, free of any deductions and without abatement, diminution or set-off. Until such time as the principal of and interest on the Bonds shall have been fully paid, or provision for the payment thereof shall have been made as required by the Indenture, the Clinic (i) will not suspend or discontinue any payments provided for in the immediately preceding paragraph; (ii) will perform and observe all of its other covenants contained in the Indenture; and (iii) except as otherwise provided in the Indenture, will not terminate the Indenture for any cause, including, without limitation, the occurrence of any act or circumstances that may constitute failure of consideration, destruction of or damage to all or a portion of the projects financed with the proceeds of the Bonds, commercial frustration of purpose, any change in the tax or other laws of the United States of America or of the State or any political subdivision of either of these, or any failure of the Trustee to perform and observe any covenant, whether express or implied, or any duty, liability or obligation arising out of or connected with the Indenture, except to the extent permitted by the Indenture.

**Validity of Bonds**

The recital contained in the Bonds that the same are issued pursuant to the Indenture shall be conclusive evidence of their validity and of compliance with the provisions of the Indenture in their issuance.

**Redemption of Bonds**

*Optional Redemption*. The Bonds are redeemable prior to maturity at the written direction of the Clinic to the Trustee at least thirty (30) days before the redemption date. Such redemption shall be in accordance with the terms of the Bonds, as a whole or in part on any Business Day in such order of maturity as directed by the Clinic at the Redemption Price.

*Selection of Bonds for Redemption Within a Maturity*. Whenever provision is made in the Indenture for the redemption of less than all of the Bonds of a maturity, the Trustee shall select the Bonds to be redeemed from all Bonds subject to redemption, by lot in any manner that is customary in the industry.

*Notice of Redemption*. Notice of redemption shall be mailed by the Clinic to the Trustee by first class mail, not less than thirty (30) days, nor more than sixty (60) days prior to the redemption date. Notice of redemption shall be mailed by the Trustee by first class mail, not less than twenty (20) days, nor more than sixty (60) days prior to the redemption date, to the respective Holders of any Bonds designated for redemption at their addresses appearing on the bond registration books of the Trustee. If the Bonds are no longer held by the Securities Depository or its successor or substitute, the Trustee shall also give notice of redemption by overnight mail to such securities depositories and/or securities information services as shall be designated in a Certificate of the Clinic. Each notice of redemption shall state the date of such notice, the date of issue of the Bonds, the redemption date, the Redemption Price, the place or

places of redemption (including the name and appropriate address or addresses of the Trustee), the maturity (including CUSIP number, if any), and, in the case of Bonds to be redeemed in part only, the portion of the principal amount thereof to be redeemed. Each such notice shall also state that on said date there will become due and payable on each of said Bonds the Redemption Price thereof or of said specified portion of the principal amount thereof in the case of a Bond to be redeemed in part only, together with interest accrued thereon to the redemption date, and that from and after such redemption date interest thereon shall cease to accrue, and shall require that such Bonds be then surrendered.

Notice of redemption of Bonds shall be given by the Trustee, at the expense of the Clinic, for and on behalf of the Clinic.

Failure by the Trustee to give notice pursuant to the Indenture to any one or more of the securities information services or depositories designated by the Clinic, or the insufficiency of any such notice shall not affect the sufficiency of the proceedings for redemption. Failure by the Trustee to mail notice of redemption pursuant to the Indenture to any one or more of the respective Holders of any Bonds designated for redemption shall not affect the sufficiency of the proceedings for redemption with respect to the Holders to whom such notice was mailed.

The Clinic may instruct the Trustee to provide conditional notice of redemption, which may be conditioned upon the receipt of moneys or any other event. Additionally, any notice given pursuant to the Indenture may be rescinded by written notice given to the Trustee by the Clinic no later than five (5) Business Days prior to the date specified for redemption. The Trustee shall give notice of such rescission, as soon thereafter as practicable, in the same manner, to the same Persons, as notice of such redemption was given pursuant to the Indenture.

*Partial Redemption of Bonds*. Upon surrender of any Bond redeemed in part only, the Clinic shall execute (but need not prepare) and the Trustee shall prepare or cause to be prepared, authenticate and deliver to the Holder thereof, at the expense of the Clinic, a new Bond or Bonds of Authorized Denominations, equal in aggregate principal amount to the unredeemed portion of the Bond surrendered.

*Effect of Redemption*. Notice of redemption having been duly given as aforesaid, and moneys for payment of the Redemption Price of, together with interest accrued to the date fixed for redemption, the Bonds (or portion thereof) so called for redemption being held by the Trustee, on the date fixed for redemption designated in such notice, the Bonds (or portion thereof) so called for redemption shall become due and payable at the Redemption Price specified in such notice and interest accrued thereon to the date fixed for redemption, interest on the Bonds so called for redemption shall cease to accrue, said Bonds (or portion thereof) shall cease to be entitled to any benefit or security under the Indenture, and the Holders of said Bonds shall have no rights in respect thereof except to receive payment of said Redemption Price and accrued interest to the date fixed for redemption from funds held by the Trustee for such payment.

All Bonds redeemed pursuant to the provisions of the Indenture shall be cancelled by the Trustee upon surrender thereof and delivered to, or upon the order of, the Clinic.

*Mandatory Redemption*. The Bonds are subject to mandatory redemption from amounts required to be deposited by the Clinic on the redemption fund on the following dates (each such date being herein referred to as a "Sinking Fund Payment Date"), an amount (hereinafter referred to as a "Sinking Fund Requirement") sufficient to redeem, on such Sinking Fund Payment Date, Bonds equal to the following principal amounts, at a redemption price or payment amount equal to the principal amount thereof to be redeemed, without premium, plus interest accrued to the date fixed for redemption or payment:

| **Sinking Fund Payment Date (November 15)** | **Sinking Fund Principal Amount** |
|---|---|
| 20[__] | $[_____] |
| 20[__] | [_____] |
| 20[__] | [_____] |
| 20[__]* | [_____] |

*Maturity

Any partial redemption of Bonds under the provisions of the Indenture for optional redemption shall reduce the mandatory sinking fund redemption requirements. In the event of such a partial redemption, the Bonds so redeemed shall be credited by the Trustee at 100% of the principal amount thereof against future mandatory sinking fund redemption requirements as shall be specified in a Certificate of the Clinic, provided, however, that until the Clinic delivers such certificate, the Trustee shall allocate the principal amount of Bonds redeemed against future mandatory sinking fund redemption requirements in chronological order.

**Use of Securities Depository**

Notwithstanding any provision of the Indenture to the contrary:

The Bonds shall be initially issued as fully registered Bonds, registered in the name of "Cede & Co.," as nominee of the Securities Depository and shall be evidenced by one Bond for each maturity in the principal amount of the Bonds of such maturity. Registered ownership of the Bonds, or any portion thereof, may not thereafter be transferred except: (1) to any successor of the Securities Depository or its nominee, or to any substitute depository designated pursuant to clause (2)of this paragraph ("substitute depository"); provided that any successor of the Securities Depository or substitute depository shall be qualified under any applicable laws to provide the service proposed to be provided by it; (2) to any substitute depository designated by the Clinic and not objected to by the Trustee, upon (i) the resignation of the Securities Depository or its successor (or any substitute depository or its successor) from its functions as depository or (ii) a determination by the Clinic that the Securities Depository or its successor (or any substitute depository or its successor) is no longer able to carry out its functions as depository; provided that any such substitute depository shall be qualified under any applicable laws to provide the services proposed to be provided by it; or (3) to any Person as provided below, upon (i) the resignation of the Securities Depository or its successor (or substitute depository or its successor) from its functions as depository; provided that no substitute depository which is not objected to by the Trustee can be obtained or (ii) a determination by the

Clinic that it is in the best interests of the Clinic to remove the Securities Depository or its successor (or any substitute depository or its successor) from its functions as depository.

In the case of any transfer pursuant to clause (1) or clause (2) of the immediately preceding paragraph, upon receipt of the Outstanding Bonds by the Trustee, together with a Certificate of the Clinic to the Trustee, new Bonds for each maturity shall be executed and delivered in the principal amount of the Bonds of such maturity, registered in the name of such successor or such substitute depository, or their nominees, as the case may be, all as specified in such Certificate of the Clinic. In the case of any transfer pursuant to clause (3) of the immediately preceding paragraph, upon receipt of the Outstanding Bonds by the Trustee together with a Certificate of the Clinic to the Trustee, new Bonds shall be executed and delivered in such denominations and registered in the names of such persons as are requested in such a Certificate of the Clinic, subject to the limitations of the Indenture, provided the Trustee shall not be required to deliver such new Bonds within a period less than sixty (60) days from the date of receipt of such a Certificate of the Clinic.

In the case of partial redemption or an advance refunding of the Bonds evidencing all or a portion of the principal amount Outstanding, the Securities Depository shall make an appropriate notation on the Bonds indicating the date and amounts of such reduction in principal, in form acceptable to the Trustee.

The Clinic and the Trustee shall be entitled to treat the Person in whose name any Bond is registered as the Bondholder thereof for all purposes of the Indenture and any applicable laws, notwithstanding any notice to the contrary received by the Clinic or the Trustee. So long as the Outstanding Bonds are registered in the name of the Cede & Co. or its registered assign, the Clinic and the Trustee shall cooperate with Cede & Co., as sole registered Bondholder, and its registered assigns, in effecting payment of the principal or Redemption Price of and interest on the Bonds by arranging for payment in such manner that funds for such payments are properly identified and are made immediately available on the date they are due, all in accordance with the letter of representations of the Clinic to the Securities Depository or as otherwise agreed by the Trustee and the Securities Depository.

**Particular Covenants**

*Punctual Payment*. The Clinic shall punctually pay the principal or Redemption Price and interest to become due in respect of all the Bonds, in strict conformity with the terms of the Bonds and of the Indenture, according to the true intent and meaning thereof. When and as paid in full, all Bonds shall be delivered to the Trustee and shall forthwith be cancelled by the Trustee and delivered to, or upon the order of, the Clinic.

*Compliance with Indenture*. The Clinic represents that no default has occurred and is continuing under the Indenture, and the Clinic shall not suffer or permit any Default (within its power to prevent) to occur under the Indenture, but shall faithfully observe and perform all the covenants, conditions and requirements of the Indenture.

*Negative Pledge*. The Clinic shall not permit any Lien other than Permitted Encumbrances to be placed upon any of its Property, nor shall it permit any of its Controlled

Affiliates to permit any Lien other than Permitted Encumbrances to be placed upon any of such Controlled Affiliate's Property, unless such Lien is also granted to secure the Bonds.

*Power to Issue Bonds and Make Pledge and Assignment*. The Clinic is duly authorized to issue the Bonds and to enter into the Indenture and to pledge and assign the funds and accounts purported to be pledged and assigned under the Indenture in the manner and to the extent provided in the Indenture. The Bonds are and will be legal, valid and binding obligations of the Clinic in accordance with their terms, and the Clinic and the Trustee shall at all times, to the extent permitted by law, defend, preserve and protect said pledge and assignment of funds and accounts and all the rights of the Bondholders under the Indenture against all claims and demands of all Persons whomsoever, subject to the limitations set forth in the Indenture relating to the Trustee.

*Accounting Records and Financial Statements*. With respect to each fund or account established and maintained by the Trustee pursuant to the Indenture, the Trustee shall at all times keep, or cause to be kept, proper books of record and account prepared in accordance with corporate trust accounting standards, in which complete and accurate entries shall be made of all transactions relating to the receipt, investment, disbursement, allocation and application of payments received from the Clinic and the proceeds of the Bonds. Such books of record and account shall be available for inspection by the Clinic and any Bondholder at reasonable hours and under reasonable circumstances.

*Insurance Coverage*. The Clinic shall carry and maintain insurance against such risks and in such amounts and with such deductible provisions as are customary in connection with business operations of the type and size comparable to that of the Clinic. The Clinic, at its option, may comply with this covenant by maintenance of a self-insurance program substantially in the form of the self-insurance program maintained by the Clinic as of the date of the Indenture or by creation and maintenance of an insurance subsidiary qualified under applicable law.

*Negative Pledge*. The Clinic shall not permit any Lien other than Permitted Encumbrances to be placed upon any of its Property, nor shall it permit any of its Controlled Affiliates to permit any Lien other than Permitted Encumbrances to be placed upon any such Controlled Affiliate's Property, unless such Lien is also granted to secure the Bonds.

*Controlled Affiliates*. The Clinic agrees that it will exercise all control or rights it may have with respect to any Controlled Affiliates to cause such Controlled Affiliates to pay, loan or otherwise transfer to the Clinic such amounts as are necessary to duly and punctually pay amounts due on the Bonds.

*Expenses of Operation and Maintenance*. The Clinic shall pay all expenses of operation and maintenance of its Property, including without limitation the expense of property insurance thereon and insurance against liability for injury to persons or property arising from the operation thereof, and all taxes and installments of special assessments levied upon or with respect to such Property and payable during the term of the Indenture.

*Compliance with Laws*. The Clinic shall comply in all material respects with all applicable laws, ordinances, rules and regulations of any governmental authority affecting the Property.

*Merger or Consolidation; Sale of Assets*. The Clinic shall not merge into or consolidate with any Third Party nor allow any Third Party to merge into or consolidate with it unless:

(a) the Clinic shall be the successor corporation in such merger or consolidation; or

(b) if the Clinic will not be the successor corporation, the Clinic shall deliver to the Trustee a Certificate to the effect that (i) after the merger or consolidation, no Event of Default shall exist under the Indenture, (ii) at the time of the merger or consolidation, the resulting or surviving entity is the controlling member or controlling shareholder (directly or indirectly) for the same corporations for which the Clinic was a controlling member or controlling shareholder immediately prior to the merger or consolidation, and (iii) at the time of the merger or consolidation, has the same power as the Clinic had immediately prior to the merger or consolidation to appoint and dismiss a majority of the members of the governing bodies of such corporations.

In case of any such merger or consolidation, such successor corporation shall succeed to and be substituted for its predecessor, with the same effect as if it had originally been the Clinic. The acquisition by the Clinic of outstanding shares of any Third Party or any other acquisition of an interest in a Third Party shall not be deemed to be a merger or consolidation.

Except as provided in the subsequent caption, the Clinic shall not sell, transfer or otherwise dispose of all or substantially all of its assets to a Third Party until either (i) all amounts due from the Clinic under the Indenture shall have been paid in full or provisions for such payment shall have been made in accordance with the Indenture, or (ii) the Third Party shall have satisfied the requirements described in the next caption, as if it were the new Parent Corporation.

*Substitution of New Parent Corporation*. In the event that, as the result of a corporate reorganization, a new parent corporation is created which holds the controlling interest in the Clinic, and also holds, directly or indirectly, the controlling interest in all Affiliates of the Clinic (determined at the time that the new parent corporation acquires the controlling interest in the Clinic), the new Parent Corporation may be substituted for the Clinic under, and the Clinic may be released from its obligations under the Indenture. Such substitution and release shall be effective only upon receipt by the Trustee of the following:

(a) A written agreement by which the new Parent Corporation assumes the obligations of the Clinic under the Indenture, together with an Opinion of Counsel to the effect that the assumption is a valid, binding and enforceable obligation of the new Parent Corporation.

(b) An opinion of Counsel that the assumption by the New Parent Corporation and the release of the Clinic will not cause any of the Bonds to become subject to registration under the Securities Act of 1933 (or that such registration, if required, has been made); and

(c) A Certificate to the effect that (i) after the assumption by the new Parent Corporation and the release of the Clinic, no Event of Default shall exist under the Indenture, (ii) at the time of the assumption, the new Parent Corporation is the controlling member or controlling shareholder (directly or indirectly) for the Clinic and the same corporations for which the Clinic was a controlling member or controlling shareholder immediately prior to the assumption, and (iii) at the time of the assumption, has the same power (directly or indirectly) as the Clinic to appoint and dismiss a majority of the members of the governing bodies of such corporations.

From and after the effective date of such substitution and release, the new Parent Corporation shall be deemed to be the "Clinic" for all purposes of the Indenture.

**Joint and Several Obligations**

The obligations, agreements, covenants and restrictions of the Indenture shall constitute joint and several obligations, agreements and covenants of and restrictions relating to all Obligated Parties. The Clinic is presently the only Obligated Party. Unless otherwise specifically set forth in the Indenture, each action taken under the Indenture by the Clinic shall be taken on behalf of all Obligated Parties.

*Additional Obligated Parties*. Any Person may become an "Obligated Party" under the Indenture upon compliance with the following conditions:(a) The Clinic shall deliver to the Trustee an Officer's Certificate confirming that after the addition of such Person no Event of Default under the Indenture shall exist.

(b) The Clinic shall deliver to the Trustee an opinion of Counsel to the effect that under then existing law the addition of such Person shall not cause any of the Bonds to become subject to registration under the Securities Act of 1933 (or that such registration, if required, has been made).

(c) Such Person shall deliver to the Trustee an agreement in form and substance satisfactory to the Trustee evidencing the assumption by such Person, jointly and severally with the other Obligated Parties, of the due and punctual payment of the principal of, premium, if any, and interest on all loans made under the Indenture and the due and punctual performance and observance of all other covenants and conditions of the Indenture to be kept and performed by the Obligated Parties under the Indenture.

(d) Such Person shall deliver to the Trustee an opinion of counsel for such Person to the effect that the agreement described in subsection (c) above has been duly authorized, executed and delivered by such Person and is the legal, valid and binding obligation of such Person, enforceable in accordance with its terms, except to the extent to which enforceability may be limited by bankruptcy, insolvency, moratorium, reorganization or other laws or equitable principles affecting creditors' rights generally.

Upon receipt of all documents required, the Trustee shall deliver to such Person and each Obligated Party a certificate stating that such Person shall become an Obligated Party, effective upon delivery of such certificate to such Person and each Obligated Party. Upon such addition, such new Obligated Party shall be jointly and severally liable for all obligations of the Obligated

Parties under the Indenture, including the obligation to pay the principal and Redemption Price of and interest on the Bonds. No Person affiliated with or controlled directly or indirectly by any Obligated Party shall be deemed to be an Obligated Party unless such Person becomes an Obligated Party.

*Release of an Obligated Party*. Any Obligated Party other than the Clinic may be released from its obligations and liabilities under the Indenture, and upon such release shall cease to be an "Obligated Party" upon compliance with the following conditions:(a) The Clinic shall deliver to the Trustee an Officer's Certificate confirming that after the release of such Obligated Party no Event of Default shall exist.

(b) The Clinic shall deliver to the Trustee an opinion of Counsel to the effect that under then existing law the release of such Obligated Party shall not cause any of the Bonds to become subject to registration under the Securities Act of 1933 (or that such registration, if required, has been made).

(c) The Clinic shall deliver to the Trustee an Officer's Certificate stating that the conditions set forth in this caption have been satisfied, accompanied by evidence of such satisfaction in form and substance satisfactory to the Trustee, and stating that such Obligated Party is to be released from its obligations and liabilities under the Indenture.

Upon request and assuming compliance with the other provisions of this caption, the Trustee shall deliver to such Obligated Party any instrument reasonably requested to evidence that such Obligated Party is released from its obligations and liabilities under the Indenture (including any Uniform Commercial Code termination statements), provided that, notwithstanding the date of delivery of any such instrument, the release of such Obligated Party shall be effective as of the date of compliance with the requirements described in this caption. Upon the release of any Obligated Party, such Obligated Party shall no longer be obligated to pay any principal of or Redemption price of, premium, if any, or interest on any Bonds and shall not be required to comply with any other provision of the Indenture.

**Events of Default and Remedies of Bondholders**

*Events of Default*. The following events shall be "Events of Default": (a) default in the due and punctual payment of the principal or Redemption Price or Sinking Fund Requirement of any Bond when and as the same shall become due and payable, whether at maturity, by proceedings for redemption, by acceleration or otherwise; (b) default in the due and punctual payment of any interest on any Bond when and as such interest shall become due and payable; (c) the Clinic shall fail to pay when due any other amounts due under the Indenture and such failure shall continue for 30 days after written notice thereof shall have been given by the Trustee to the Clinic; (d) the Clinic shall fail to perform any covenant or agreement to be performed by it under the Indenture (other than a covenant, agreement or condition a default in performance or observance of which is elsewhere in this caption specifically dealt with and other than the covenants described in "Particular Covenants--Accounting Records and Financial Statements" hereinabove, breach of which shall be remedied by specific performance) and such Default shall continue for 30 days after written notice thereof shall have been given by the Trustee to the Clinic, provided, however, that if the Clinic notifies the Trustee that such failure can be cured but

not within such 30-day period, such failure shall not be an Event of Default under the Indenture until 90 days after receipt of such notice so long as the Clinic has commenced and is diligently pursuing a cure thereof during such 90-day period; (e) any representation made by the Clinic in the Indenture or in any document or certificate furnished by it in connection with the Indenture or pursuant to the Indenture shall prove at any time to be incorrect or misleading in any material respect as of the date made and such representation, if capable of being cured, shall not have been cured within 30 days after written notice thereof shall have been given by the Trustee to the Clinic or (f) an Act of Bankruptcy shall occur.

Notwithstanding the foregoing, if by reason of acts of God; strikes, lockouts or other industrial disturbances; acts of public enemies; orders of any kind of the government of the United States or of the State or of any department, agency, political subdivision, court or official of any of them or any civil or military authority; insurrections; riots; epidemics; landslides, lightning, earthquakes, volcanoes, fires, hurricanes, tornadoes, storms, floods, washouts, droughts other natural disaster; arrests; restraint of government and people; civil disturbances; explosions; breakage or accident to machinery; partial or entire failure of utilities; or any cause or event not reasonably within the control of the Clinic, the Clinic is unable in whole or in part to carry out any one or more of its agreements or obligations contained in the Indenture, other than its obligation to pay principal or Redemption Price and interest to become due in respect of all the Bonds, the Clinic shall not be deemed in default under (d) in the preceding paragraph (nor shall any such Default become an Event of Default) with respect thereto during the continuance of such inability. The Clinic shall make reasonable efforts to remedy with all reasonable dispatch the cause or causes preventing it from carrying out its agreements; provided that the settlement of strikes, lockouts and other industrial disturbances shall be entirely within the discretion of the Clinic.

*Acceleration of Maturity*. If an Event of Default shall occur, then, and in each and every such case during the continuance of such Event of Default, the Trustee may, upon notice in writing to the Clinic, and shall, at the written request of the Owners of not less than 25% of the aggregate principal amount of Bonds then Outstanding, declare the principal of all the Bonds then Outstanding, and the interest accrued thereon, to be due and payable immediately, and upon any such declaration by the Trustee the same shall become and shall be immediately due and payable, anything in the Indenture or in the Bonds contained to the contrary notwithstanding, provided, however, that upon the occurrence of an Act of Bankruptcy, the Bonds shall become and be immediately due and payable without any declaration, notice or further action.

Any such declaration, however, is subject to the condition that if, at any time after such declaration and before any judgment or decree for the payment of the moneys due shall have been obtained or entered, there shall be deposited with the Trustee a sum sufficient to pay all the principal or Redemption Price of and interest on the Bonds payment of which is overdue, with interest on such overdue principal at the rate borne by the Bonds, and the reasonable charges and expenses of the Trustee, and any and all other Defaults known to the Trustee (other than in the payment of principal of and interest on the Bonds due and payable solely by reason of such declaration) shall have been made good or cured to the satisfaction of the Trustee or provision deemed by the Trustee to be adequate shall have been made therefor, then, and in every such case, the Trustee shall, on behalf of the Holders of all of the Bonds, by written notice to the Clinic, rescind and annul such declaration and its consequences and waive such Default; but no

such rescission and annulment shall extend to or shall affect any subsequent Default, or shall impair or exhaust any right or power consequent thereon.

*Rights as a Secured Party*. The Trustee, as appropriate, may exercise all of the rights and remedies of a secured party under the Uniform Commercial Code with respect to securities in the Indenture Fund, including without limitation the Bond Fund and the Redemption Fund, including the right to sell or redeem such securities and the right to retain the securities in satisfaction of the obligation of the Clinic under the Indenture. Notice sent by registered or certified mail, postage prepaid, or delivered during business hours, to the Clinic at least seven (7) days before an event under Uniform Commercial Code Sections 9-610 and 9-611, or any successor provision of law shall constitute reasonable notification of such event.

*Application of Moneys Collected by the Trustee*. All moneys received by the Trustee pursuant to any right given or action taken under the Indenture pursuant to an Event of Default shall, after payment of the cost and expenses of the proceedings resulting in the collection of such moneys and of the related fees of, expenses, liabilities and advances incurred or made by, the Trustee, be applied as follows:

(a) Unless the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied:

First: To the payment to the Persons entitled thereto of all installments of interest then due on the Bonds, in the order of the maturity of the installments of such interest, and, if the amount available shall not be sufficient to pay in full any particular installment, then to the payment ratably, according to the amounts due on such installment, to the Persons entitled thereto, without any discrimination or privilege; and

Second: To the payment to the Persons entitled thereto of the unpaid principal or Redemption Price of the Bonds which shall have become due, in the order of their due dates, with interest on such amounts at the rate last borne by such Bonds from the respective dates on which they became due to the date of payment, and, if the amount available shall not be sufficient to pay in full the principal or Redemption Price which became due on such Bonds on any particular date, together with such interest, then to the payment thereof ratably, according to the amount of principal due on such date, to the Persons entitled thereto, without any discrimination or privilege.

(b) If the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied to the payment of the principal or Redemption Price and interest then due and unpaid on the Bonds, without preference or priority of principal or Redemption Price over interest or of interest over principal or Redemption Price or of any installment of interest over any other installment of interest or of any Bond over any other Bond, ratably, according to the amounts due respectively for principal and interest on any Bond, to the Persons entitled thereto, without any discrimination or privilege.

(c) If the principal of all the Bonds shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled in accordance with the

Indenture, then the moneys to be applied as described in this caption shall be applied in accordance with the provisions of subsection (a) of this caption.

(d) Whenever moneys are to be applied by the Trustee as described in this caption, such moneys shall be applied at such times and from time to time as the Trustee shall determine, having due regard for the amount of such moneys available for application and the likelihood of additional moneys become available for such application. Whenever the Trustee shall apply such moneys, it shall fix the date (which shall be an interest payment date unless it shall deem another date more suitable) upon which such application is to be made and upon such date interest on the amounts of principal to be paid on such dates shall cease to accrue, provided that such amount of principal is in fact paid on such date. The Trustee shall give such notice as it may deem appropriate of the deposit with it of any such moneys and of the fixing of any such date, and shall not be required to make payment from such moneys to the Holder of any Bond until such Bond shall be presented to the Trustee.

(e) Whenever all Bonds and interest thereon have been paid as described in this caption and all expenses and charges of the Trustee and any authenticating agent, any other paying agent and any other fiduciary which have accrued and which will accrue with respect to the Bonds have been paid, any balance remaining shall be paid to the Holders entitled to receive the same, and if no other Person shall be entitled thereto, then the balance shall be paid to the Clinic.

(f) Notwithstanding the foregoing, any moneys received from security which is not pledged or assigned to the Trustee generally but which secures a particular Bond shall be applied only as provided by the instrument granting such security or the laws or other contractual obligations governing application of any moneys received on account of such security.

*Trustee to Represent Bondholders*. The Trustee is irrevocably appointed (and the successive respective Holders of the Bonds, by taking and holding the same, shall be conclusively deemed to have so appointed the Trustee) as trustee and true and lawful attorney-in-fact of the Holders of the Bonds for the purpose of exercising and prosecuting on their behalf such rights and remedies as may be available to such Holders under the provisions of the Bonds, the Indenture and applicable provisions of any law. Upon the occurrence and continuance of an Event of Default or other occasion giving rise to a right in the Trustee to represent the Bondholders, the Trustee in its discretion may, and upon the written request of the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding, and upon being indemnified to its satisfaction therefor, shall, proceed to protect or enforce its rights or the rights of such Holders by such appropriate action, suit, mandamus or other proceedings as it shall deem most effectual to protect and enforce any such right, at law or in equity, either for the specific performance of any covenant or agreement contained in the Indenture, or in aid of the execution of any power granted in the Indenture, or for the enforcement of any other appropriate legal or equitable right or remedy vested in the Trustee, or in such Holders under the Bonds, the Indenture or any applicable law; and upon instituting such proceeding, the Trustee shall be entitled, as a matter of right, to the appointment of a receiver of the amounts pledged under the Indenture, pending such proceedings. All rights of action under the Indenture or the Bonds or otherwise may be prosecuted and enforced by the Trustee without the possession of any of the Bonds or the production thereof in any proceeding relating thereto, and any such suit, action or

proceeding instituted by the Trustee shall be brought in the name of the Trustee for the benefit and protection of all the Holders of such Bonds, subject to the provisions of the Indenture.

*Bondholders' Direction of Proceedings*. The Holders of a majority in aggregate principal amount of the Bonds then Outstanding shall have the right, by an instrument or concurrent instruments in writing executed and delivered to the Trustee, and upon indemnifying the Trustee to its satisfaction therefor, to direct the time, method and place of conducting all remedial proceedings taken by the Trustee under the Indenture, provided that such direction shall not be otherwise than in accordance with law and the provisions of the Indenture, and that the Trustee shall have the right to decline to follow any such direction which in the opinion of the Trustee would be unjustly prejudicial to Bondholders not parties to such direction.

*Limitation on Bondholders' Right to Sue*. No Holder of any Bond shall have the right to institute any suit, action or proceeding at law or in equity, for the protection or enforcement of any right or remedy under the Indenture or any applicable law with respect to such Bond, unless (1) such Holder shall have given to the Trustee written notice of the occurrence of an Event of Default; (2) the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding shall have made written request upon the Trustee to exercise the powers granted in the Indenture or to institute such suit, action or proceeding in its own name; (3) such Holder or said Holders shall have tendered to the Trustee indemnity satisfactory to it against the costs, expenses and liabilities to be incurred in compliance with such request; and (4) the Trustee shall have refused or omitted to comply with such request for a period of sixty (60) days after such written request shall have been received by, and said tender of indemnity shall have been made to, the Trustee.

Such notification, request, tender of indemnity and refusal or omission are declared by the Indenture, in every case, to be conditions precedent to the exercise by any Holder of Bonds of any remedy under the Indenture or under law; it being understood and intended that no one or more Holders of Bonds shall have any right in any manner whatever by his or their action to affect, disturb or prejudice the security of the Indenture or the rights of any other Holders of Bonds, or to enforce any right under the Indenture or applicable law with respect to the Bonds, except in the manner provided in the Indenture, and that all proceedings at law or in equity to enforce any such right shall be instituted, had and maintained in the manner provided in the Indenture and for the benefit and protection of all Holders of the Outstanding Bonds, subject to the provisions of the Indenture.

*Absolute Obligation of Clinic*. Notwithstanding any other provision of the Indenture, or in the Bonds, nothing shall affect or impair the obligation of the Clinic, which is absolute and unconditional, to pay the principal or Redemption Price of and interest on the Bonds to the respective Holders of the Bonds at their respective dates of maturity, or upon call for redemption, as provided in the Indenture, or, subject to the provisions of the Indenture regarding limitation on Bondholders' right to sue, affect or impair the right of such Holders to enforce such payment by virtue of the contract embodied in the Bonds.

*Termination of Proceedings*. In case any proceedings taken by the Trustee or any one or more Bondholders on account of any Event of Default shall have been discontinued or abandoned for any reason or shall have been determined adversely to the Trustee or the

Bondholders, then in every such case the Clinic, the Trustee and the Bondholders, subject to any determination in such proceedings, shall be restored to their former positions and rights under the Indenture, severally and respectively, and all rights, remedies, powers and duties of the Clinic, the Trustee and the Bondholders shall continue as though no such proceedings had been taken.

*Remedies Not Exclusive*. No remedy conferred in the Indenture upon or reserved to the Trustee or to the Holders of the Bonds is intended to be exclusive of any other remedy or remedies, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy given under the Indenture or now or hereafter existing at law or in equity or otherwise.

*Delay or Omission Not Waiver*. No delay or omission of the Trustee or of any Holder of the Bonds to exercise any right or power arising upon the occurrence of any Default shall impair any such right or power or shall be construed to be a waiver of any such Default or an acquiescence therein; and every power and remedy given by the Indenture to the Trustee or to the Holders of the Bonds may be exercised from time to time and as often as may be deemed expedient.

*Waiver of Past Defaults*. The Trustee may, and upon request of the Holders of not less than a majority in aggregate principal amount of the Outstanding Bonds and upon receipt of indemnification satisfactory to the Trustee shall, on behalf of the Holders of all the Bonds waive any past Default under the Indenture and its consequences, except a Default: (A) In the payment of the principal or Redemption Price of or interest on any Bond, or (B) in respect of a covenant or other provision of the Indenture which, pursuant to the Indenture, cannot be modified or amended without the consent of the Holder of each Outstanding Bond affected. Upon any such waiver, such Default shall cease to exist, and any Event of Default arising therefrom shall be deemed to have been cured, for every purpose of the Indenture, but no such waiver shall extend to any subsequent or other Default or impair any right consequent thereon.

*Undertaking for Costs*. Subject to the provisions of the Indenture regarding the Trustee's rights to compensation and indemnification, the parties to the Indenture agree, and each Holder of any Bond by such Person's acceptance thereof shall be deemed to have agreed, that any court may in its discretion require, in any suit for the enforcement of any right or remedy under the Indenture, or in any suit against the Trustee for any action taken or omitted by it as Trustee, the filing by any party litigant in such suit of an undertaking to pay the costs of such suit, and that such court may in its discretion assess reasonable costs, including reasonable attorneys fees, against any party litigant in such suit, having due regard to the merits and good faith of the claims or defenses made by such party litigant; but the provisions of this paragraph shall not apply to any suit instituted by the Trustee or to any suit instituted by any Bondholder or group of Bondholders holding in the aggregate more than a majority in aggregate principal amount of the Outstanding Bonds.

*Notice of Default*. Upon a Responsible Officer's actual knowledge of the existence of any Default under the Indenture, the Trustee shall notify the Clinic in writing as soon as practicable, but in any event within five (5) Business Days.

Upon a Responsible Officer's actual knowledge of the existence of any Default under the Indenture, the Trustee shall transmit by mail to all Bondholders, as their names and addresses appear in the bond register, notice of such Default under the Indenture within ninety (90) days, unless such Default shall have been cured or waived; provided, however, that, except in the case of a Default in the payment of the principal or Redemption Price of or interest on any Bond, the Trustee shall be protected in withholding such notice if and so long as the board of directors, the executive committee or a trust committee of directors or Responsible Officers of the Trustee in good faith determine that the withholding of such notice is in the interest of the Bondholders; and provided, further, that in the case of any Default of the character specified in (c) under "Events of Default" above, no such notice to Bondholders shall be given until at least thirty (30) days after the occurrence thereof.

*Trustee May File Proofs of Claim*. In case of the pendency of any receivership, insolvency, liquidation, bankruptcy, reorganization, arrangement, adjustment, composition or other judicial proceeding relative to the Clinic or any other obligor upon the Bonds or the property of the Clinic or of such other obligor or their creditors, the Trustee (irrespective of whether the principal of the Bonds shall then be due and payable as therein expressed or by declaration or otherwise and irrespective of whether the Trustee shall have made any demand on the Clinic for the payment of overdue principal or interest) shall be entitled and empowered, by intervention in such proceeding or otherwise: (1) to file and prove a claim for the whole amount of principal (or Redemption Price) and interest owing and unpaid in respect of the Bonds and to file such other papers or documents as may be necessary or advisable in order to have the claims of the Trustee (including any claim for the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel including expenses and fees of outside counsel and allocated costs of internal legal counsel) and of the Bondholders allowed in such judicial proceeding; and (2) to collect and receive any moneys or other property payable or deliverable on any such claims and to distribute the same; and any receiver, assignee, trustee, liquidator or sequestrator (or other similar official) in any such judicial proceeding is, by the Indenture, authorized by each Bondholder to make such payments to the Trustee and, in the event that the Trustee shall consent to the making of such payments directly to the Bondholders, to pay to the Trustee any amount due to it for the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel including expenses and fees of outside counsel and allocated costs of internal legal counsel, and any other amounts due the Trustee under the Indenture.

Nothing contained in the Indenture shall be deemed to authorize the Trustee to authorize or consent to or accept or adopt on behalf of any Bondholder any plan of reorganization, arrangement, adjustment or composition affecting the Bonds or the rights of any Holder thereof, or to authorize the Trustee to vote in respect of the claim of any Bondholder in any such proceeding.

**The Trustee**

*Duties, Immunities and Liabilities of Trustee*. The Trustee shall, prior to an Event of Default, and after the curing or waiver of all Events of Default which may have occurred, perform such duties and only such duties as are specifically set forth in the Indenture, and, except to the extent required by law, no implied covenants or obligations shall be read into the Indenture

against the Trustee. The Trustee shall, during the existence of any Event of Default (which has not been cured or waived), exercise such of the rights and powers vested in it by the Indenture, and use the same degree of care and skill in their exercise, as a prudent person would exercise or use under the circumstances in the conduct of such person's own affairs.

The Clinic may remove the Trustee at any time unless an Event of Default shall have occurred and then be continuing, and shall remove the Trustee if at any time requested to do so by an instrument or concurrent instruments in writing signed by the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding (or their attorneys duly authorized in writing) or if at any time the Trustee shall cease to be eligible in accordance with the Indenture, or shall become incapable of acting, or shall be adjudged a bankrupt or insolvent, or a receiver of the Trustee or its property shall be appointed, or any public officer shall take control or charge of the Trustee or of its property or affairs for the purpose of rehabilitation, conservation or liquidation, in each case by giving written notice of such removal to the Trustee, and thereupon shall appoint a successor Trustee by an instrument in writing.

The Trustee may at any time resign by giving written notice of such resignation to the Clinic and by giving the Bondholders notice of such resignation by mail at the addresses shown on the registration books maintained by the Trustee. Upon receiving such notice of resignation, the Clinic shall promptly appoint a successor Trustee by an instrument in writing. The Trustee shall not be relieved of its duties until such successor Trustee has accepted appointment.

Any removal or resignation of the Trustee and appointment of a successor Trustee shall become effective upon acceptance of appointment by the successor Trustee. If no successor Trustee shall have been appointed and have accepted appointment within thirty (30) days of giving notice of removal or notice of resignation as aforesaid, the resigning Trustee or any Bondholder (on behalf of itself and all other Bondholders) may petition any court of competent jurisdiction for the appointment of a successor Trustee, and such court may thereupon, after such notice (if any) as it may deem proper, appoint such successor Trustee. Any successor Trustee appointed under the Indenture, shall signify its acceptance of such appointment by executing and delivering to the Clinic and to its predecessor Trustee a written acceptance thereof, and thereupon such successor Trustee, without any further act, deed or conveyance, shall become vested with all the moneys, estates, properties, rights, powers, trusts, duties and obligations of such predecessor Trustee, with like effect as if originally named Trustee in the Indenture; but, nevertheless at the request of the successor Trustee, such predecessor Trustee shall execute and deliver any and all instruments of conveyance or further assurance and do such other things as may reasonably be required for more fully and certainly vesting in and confirming to such successor Trustee all the right, title and interest of such predecessor Trustee in and to any property held by it under the Indenture and shall pay over, transfer, assign and deliver to the successor Trustee any money or other property subject to the trusts and conditions set forth in the Indenture. Upon request of the successor Trustee, the Clinic shall execute and deliver any and all instruments as may be reasonably required for more fully and certainly vesting in and confirming to such successor Trustee all such moneys, estates, properties, rights, powers, trusts, duties and obligations. Upon acceptance of appointment by a successor Trustee as provided in this paragraph, the Clinic shall mail or cause to be mailed (at the expense of the Clinic) a notice of the succession of such Trustee to the trusts under the Indenture to the Bondholders at the addresses shown on the registration books maintained by the Trustee. If the Clinic fails to mail

such notice within fifteen (15) days after acceptance of appointment by the successor Trustee, the successor Trustee shall cause such notice to be mailed at the expense of the Clinic.

Any successor Trustee shall be a trust company or national banking association having a combined capital and surplus of (or if such trust company or bank is a member of a bank holding system, its bank holding company shall have a combined capital and surplus of) at least fifty million dollars ($50,000,000), and subject to supervision or examination by federal or State authority. If such bank or trust company publishes a report of condition at least annually, pursuant to law or to the requirements of any supervising or examining authority above referred to, then for the purpose of this subsection the combined capital and surplus of such bank or trust company shall be deemed to be its combined capital and surplus as set forth in its most recent report of condition so published. In case at any time the Trustee shall cease to be eligible in accordance with the provisions of this paragraph, the Trustee shall resign immediately in the manner and with the effect specified in the Indenture.

*Preservation and Inspection of Documents*. All documents received by the Trustee under the provisions of the Indenture shall be retained in its possession and shall be subject upon prior written notice to the inspection of the Clinic and any Bondholder, and their agents and representatives duly authorized in writing, at reasonable hours and under reasonable conditions.

**Modification or Amendment of the Indenture**

*Amendments Permitted*. The Indenture and the rights and obligations of the Clinic and of the Holders of the Bonds and of the Trustee may be modified or amended from time to time and at any time by an indenture or indentures supplemental to the Indenture, which the Clinic and the Trustee may enter into when the written consent of the Holders of a majority in aggregate principal amount of the Bonds then Outstanding shall have been filed with the Trustee. No such modification or amendment shall permit (1) a change in the date on which the principal of, premium, if any, or interest on any Bond is or is to become due and payable or a change in the date or dates on which redemption of any Bond is permitted; (2) a reduction in the principal amount of any Bond or the premium, if any, or rate of interest payable thereon or Redemption Price thereof, (3) a privilege or priority in right of payment of any Bond or Bonds over any other Bond or Bonds or (4) a reduction in the aggregate principal amount of Bonds the Holders of which are required to consent to any such supplemental indenture or to rescind or annul an Event of Default, without in any such case the consent of the Owners of all the Bonds at the time Outstanding which would be affected thereby. Promptly after the execution by the Clinic and the Trustee of any Supplemental Indenture pursuant to this paragraph, the Trustee shall mail a notice, setting forth in general terms the substance of such Supplemental Indenture, to the Bondholders at the addresses shown on the registration books maintained by the Trustee. Any failure to give such notice, or any defect therein, shall not, however, in any way impair or affect the validity of any such Supplemental Indenture.

The Indenture and the rights and obligations of the Clinic, of the Trustee and of the Holders of the Bonds may also be modified or amended from time to time and at any time by an indenture or indentures supplemental to the Indenture, which the Clinic and the Trustee may enter into without the necessity of obtaining the consent of any Bondholders, but only to the extent permitted by law and only for any one or more of the following purposes: (1) to grant to

or confer upon the Trustee for the benefit of the Owners of Bonds any additional rights, remedies, powers or authorities that may lawfully be granted to or conferred upon such Owners and the Trustee or either of them; (2) to add to the covenants and agreements of the Clinic contained in the Indenture other covenants and agreements thereafter to be observed, to pledge or assign additional security for the Bonds (or any portion thereof), or to surrender any right or power reserved in the Indenture to or conferred upon the Clinic, provided that such covenant, agreement, pledge, assignment or surrender shall not materially adversely affect the interests of the Holders of the Bonds; (3) to make such provisions for the purpose of curing any ambiguity, inconsistency or omission, or of curing or correcting any defective provision, contained in the Indenture, or in regard to matters or questions arising under the Indenture, as the Clinic or the Trustee may deem necessary or desirable and not inconsistent with the Indenture, and which shall not materially adversely affect the interests of the Holders of the Bonds; (4) to modify, amend or supplement the Indenture or any Supplemental Indenture in such manner as to permit the qualification of the Indenture under the Trust Indenture Act of 1939, as amended, or any similar federal statute hereafter in effect, and to add such other terms, conditions and provisions as may be permitted by said act or similar federal statute, and which shall not materially adversely affect the interests of the Holders of the Bonds (provided, however, that such modifications, amendments, supplements and additions shall be permitted under this paragraph only if qualification under said act or similar federal statute is required by applicable law now or hereafter in effect); (5) to make such other provisions in regard to matters or questions arising under the Indenture as the Trustee determines do not materially adversely affect the Owner of any Bond or (6) to provide for the procedures required to permit any Bondholder, at its option, to utilize an uncertificated system of registration of its Bond or to facilitate the registration of the Bonds in the name of a nominee of the Securities Depository in accordance with the provisions of the Indenture.

The Trustee may in its discretion, but shall not be obligated to, enter into any such Supplemental Indenture authorized by either of the two preceding paragraphs which materially adversely affects the Trustee's own rights, duties or immunities under the Indenture or otherwise.

*Effect of Supplemental Indenture*. Upon the execution of any Supplemental Indenture pursuant to the Indenture, the Indenture shall be deemed to be modified and amended in accordance therewith, and the respective rights, duties and obligations under the Indenture of the Clinic, the Trustee and all Holders of Bonds Outstanding shall thereafter be determined, exercised and enforced under the Indenture subject in all respects to such modification and amendment, and all the terms and conditions of any such Supplemental Indenture shall be deemed to be part of the terms and conditions of the Indenture for any and all purposes.

*Amendment of Particular Bonds*. The provisions of the Indenture regarding modification or amendment of the Indenture shall not prevent any Bondholder from accepting any amendment as to the particular Bonds held by such Bondholder, provided that due notation thereof is made on such Bonds.

**Defeasance**

*Discharge of Indenture*. The Bonds may be paid or discharged by the Clinic or the Trustee on behalf of the Clinic in any of the following ways: (A) by paying or causing to be paid

the principal or Redemption Price of and interest on all Bonds Outstanding, as and when the same become due and payable; (B) by depositing with the Trustee, in trust, at or before maturity, moneys or securities in the necessary amount (as provided in the Indenture) to pay when due or redeem all Bonds then Outstanding; or (C) by delivering to the Trustee, for cancellation by it, all Bonds then Outstanding.

If the Clinic shall also pay or cause to be paid all other sums payable under the Indenture by the Clinic, then and in that case at the election of the Clinic (evidenced by a Certificate of the Clinic filed with the Trustee signifying the intention of the Clinic to discharge all such indebtedness and the Indenture and upon receipt by the Trustee of an Opinion of Counsel to the effect that the obligations under the Indenture and the Bonds have been discharged), and notwithstanding that any Bonds shall not have been surrendered for payment, the Indenture and the pledge of the Indenture Fund and all amounts held therein made under the Indenture and all covenants, agreements and other obligations of the Clinic under the Indenture (except as otherwise provided in the Indenture) shall cease, terminate, become void and be completely discharged and satisfied and the Bonds shall be deemed paid. In such event, upon the request of the Clinic, the Trustee shall cause an accounting for such period or periods as may be requested by the Clinic to be prepared and filed with the Clinic and shall execute and deliver to the Clinic all such instruments as may be necessary to evidence such discharge and satisfaction, and the Trustee shall pay over, transfer, assign or deliver to the Clinic all moneys or securities or other property held by it pursuant to the Indenture which are not required for the payment or redemption of Bonds not theretofore surrendered for such payment or redemption.

*Discharge of Liability on Bonds*. Upon the deposit with the Trustee, in trust, at or before maturity, of money or securities in the necessary amount (as provided in the Indenture) to pay or redeem any Outstanding Bond (whether upon or prior to its maturity or the redemption date of such Bond), provided that, if such Bond is to be redeemed prior to maturity, notice of such redemption shall have been given as provided in the Indenture or provision satisfactory to the Trustee shall have been made for the giving of such notice, then all liability of the Clinic in respect of such Bond shall cease, terminate and be completely discharged, and the Bonds shall be deemed paid, except only that thereafter the Holder thereof shall be entitled to payment of the principal or Redemption Price of and interest on such Bond by the Clinic, and the Clinic shall remain liable for such payments, but only out of such money or securities deposited with the Trustee as aforesaid for their payment, subject, however, to the provisions of the Indenture regarding payment of Bonds after discharge of the Indenture.

The Clinic may at any time surrender to the Trustee for cancellation by it any Bonds previously issued and delivered, which the Clinic may have acquired in any manner whatsoever, and such Bonds, upon such surrender and cancellation, shall be deemed to be paid and retired.

*Payment of Bonds After Discharge of Indenture*. Notwithstanding any provisions of the Indenture, any moneys held by the Trustee in trust for the payment of the principal or Redemption Price of, or interest on, any Bonds and remaining unclaimed for three years (or, if shorter, one day before such moneys would escheat to the State under then applicable State law) after such principal, Redemption Price or interest, as the case may be, has become due and payable (whether at maturity or upon call for redemption), shall be repaid to the Clinic free from the trusts created by the Indenture upon receipt of an indemnification agreement acceptable to

the Clinic and the Trustee indemnifying the Clinic and the Trustee with respect to claims of Holders of Bonds which have not yet been paid, and all liability of the Trustee and the Clinic with respect to such moneys shall thereupon cease; provided, however, that before the repayment of such moneys to the Clinic as aforesaid, the Trustee may (at the cost of the Clinic) first mail to the Holders of Bonds which have not yet been paid, at the addresses shown on the registration books maintained by the Trustee, a notice, in such form as may be deemed appropriate by the Trustee with respect to the Bonds so payable and not presented and with respect to the provisions relating to the repayment to the Clinic of the moneys held for the payment thereof.

**Limitation of Rights to Parties and Bondholders**

Nothing in the Indenture or in the Bonds expressed or implied is intended or shall be construed to give to any Person other than the Clinic, the Trustee and the Holders of the Bonds, any legal or equitable right, remedy or claim under or in respect of the Indenture or any covenant, condition or provision therein contained; and all such covenants, conditions and provisions are and shall be held to be for the sole and exclusive benefit of the Clinic, the Trustee and the Holders of the Bonds.

**Evidence of Rights of Bondholders**

Any request, consent or other instrument required or permitted by the Indenture to be signed and executed by Bondholders may be in any number of concurrent instruments of substantially similar tenor and shall be signed or executed by such Bondholders in Person or by an agent or agents duly appointed in writing.

The fact and date of the execution by any Person of any such request, consent or other instrument or writing may be proved by the certificate of any notary public or other officer of any jurisdiction, authorized by the laws thereof to take acknowledgments of deeds, certifying that the Person signing such request, consent or other instrument acknowledged to him the execution thereof, or by an affidavit of a witness of such execution duly sworn to before such notary public or other officer.

The ownership of Bonds shall be proved by the registration books for the Bonds held by the Trustee.

Any request, consent, or other instrument or writing of the Holder of any Bond shall bind every future Holder of the same Bond and the Holder of every Bond issued in exchange therefor or in lieu thereof, in respect of anything done or suffered to be done by the Trustee or the Clinic in accordance therewith or reliance thereon.

**Waiver of Personal Liability**

No member, officer, agent or employee of the Clinic shall be individually or personally liable for the payment of the principal or Redemption Price of or interest on the Bonds or be subject to any personal liability or accountability by reason of the issuance thereof or the performance of any duty under the Indenture; but nothing contained in the Indenture shall relieve any such member, officer, agent or employee from the performance of any official duty provided by law or by the Indenture.

**Governing Law; Venue**

The Indenture shall be construed in accordance with and governed by the Constitution and the laws of the State applicable to contracts made and performed in the State. The Indenture shall be enforceable in the State, provided, however, that any action arising under the Indenture shall (unless waived by the Clinic) be filed and maintained in the State.

**CUSIP Numbers**

Neither the Trustee nor the Clinic shall be liable for any defect or inaccuracy in the CUSIP number that appears on any Bond or in any redemption notice. The Trustee may, in its discretion, include in any redemption notice a statement to the effect that the CUSIP numbers on the Bonds have been assigned by an independent service and are included in such notice solely for the convenience of the Holders and that neither the Trustee nor the Clinic shall be liable for any inaccuracies in such numbers.

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# APPENDIX D

## Form of Opinion of Bond Counsel

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Merrill Lynch, Pierce, Fenner & Smith Incorporated
New York, New York

Mayo Clinic
Rochester, Minnesota

Wells Fargo Bank, National Association
Minneapolis, Minnesota

Wells Fargo Securities, LLC
Minneapolis, Minnesota

Re: $_____ Taxable Bonds, Series 2016
Mayo Clinic

Ladies and Gentlemen:

We have acted as bond counsel to Mayo Clinic (the "Clinic") in connection with the issuance of $_____ aggregate principal amount of its Taxable Bonds, Series 2016 (the "Bonds"). The Bonds are issued under and pursuant to an Indenture of Trust dated as of March 1, 2016 (the "Indenture") between the Clinic and Wells Fargo Bank, National Association, as trustee (the "Trustee").

In our capacity as bond counsel, we have examined such documents, records of the Clinic and other instruments as we deemed necessary to enable us to express the opinions set forth below, including original counterparts or certified copies of the Indenture and other documents listed in the closing index for the Bonds. We have also examined an executed Bond, authenticated by the Trustee. We have also assumed that the Indenture has been duly authorized, executed and delivered by the Trustee.

Based on the foregoing, it is our opinion that:

1. The Clinic is a nonprofit corporation organized and validly existing under the laws of the State of Minnesota, with full power and authority to execute and deliver the Indenture and the Bonds.

2. The Indenture has been duly authorized, executed and delivered by the Clinic and constitutes a valid and binding obligation of the Clinic enforceable in accordance with its terms, except as the rights created thereunder and the enforcement thereof may be limited by (i) state and federal laws, rulings, decisions and principles of equity and public policy affecting remedies, (ii) bankruptcy, insolvency, reorganization, moratorium, fraudulent conveyance and other similar laws affecting creditors' rights heretofore or hereafter enacted to the extent constitutionally applicable and (iii) the exercise of judicial discretion in appropriate cases.

3. The issuance and sale of the Bonds have been duly authorized by the Clinic. The Bonds have been duly executed and delivered by the Clinic and authenticated by the Trustee, are valid and binding obligations of the Clinic and are entitled to the benefit and security of the Indenture, except as the rights created thereunder and the enforcement thereof may be limited as indicated in paragraph 2.

In rendering this opinion we have relied upon the opinion dated the date hereof of the Senior Legal Counsel of Mayo Clinic, counsel to the Clinic.

We express no opinion herein with respect to the adequacy of the security or sources of payment for the Bonds or the accuracy or completeness of any offering document used in connection with the sale of the Bonds.

Dated: March [__], 2016.

Very truly yours,

# APPENDIX E

## Global Clearance Procedures

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## GLOBAL CLEARANCE PROCEDURES

The Bonds initially will be registered in the name of Cede & Co. as registered owner and nominee for DTC, which will act as securities depository for the Bonds. Purchases of the Bonds will be in book-entry form only. Clearstream and Euroclear may hold omnibus positions on behalf of their participants through customers' securities accounts in Clearstream's and/or Euroclear's names on the books of their respective U.S. Depositories, which, in turn, hold such positions in customers' securities accounts in the U.S. Depositories' names on the books of DTC. Citibank, N.A. acts as the U.S. Depository for Clearstream and JPMorgan Chase Bank acts as the U.S. Depository for Euroclear.

### Clearstream, Luxembourg

Clearstream Banking, *société anonyme*, Luxembourg ("Clearstream, Luxembourg") advises that it is incorporated under the laws of Luxembourg as a professional depository. Clearstream, Luxembourg holds securities for its customers and facilitates the clearance and settlement of securities transactions between its customers through electronic book-entry changes in accounts of its customers, thus eliminating the need for physical movement of certificates. Clearstream, Luxembourg provides to its customers, among other things, services for safekeeping, administration, clearance and settlement of internationally traded securities and securities lending and borrowing. Clearstream, Luxembourg interfaces with domestic markets in a number of countries. Clearstream, Luxembourg is an indirect participant in DTC.

Clearstream, Luxembourg customers are recognized financial institutions around the world, including underwriters, securities brokers and dealers, banks, trust companies, clearing corporations and certain other organizations. Indirect access to Clearstream, Luxembourg is also available to others, such as banks, brokers, dealers and trust companies that clear through, or maintain a custodial relationship with, a Clearstream, Luxembourg customer either directly or indirectly.

Distributions with respect to the Bonds held beneficially through Clearstream, Luxembourg will be credited to cash accounts of Clearstream, Luxembourg participants in accordance with its rules and procedures, to the extent received by Clearstream, Luxembourg.

### The Euroclear System

Euroclear Bank S.A./N.V. ("Euroclear") has advised us that the Euroclear System was created in 1968 to hold securities for participants in the Euroclear System and to clear and settle transactions between Euroclear participants through simultaneous electronic book-entry delivery against payment, thus eliminating the need for physical movement of certificates and risk from lack of simultaneous transfers of securities and cash. Transactions may now be settled in many currencies, including United States dollars. The Euroclear System provides various other services, including securities lending and borrowing and interfaces with domestic markets in several countries generally similar to the arrangements for cross-market transfers with DTC described below.

The Euroclear System is operated by Euroclear (the "Euroclear Operator"), under contract with Euroclear Clearance System, S.C., a Belgian cooperative corporation. The Euroclear Operator conducts all operations, and all Euroclear securities clearance accounts and Euroclear cash accounts are accounts with the Euroclear Operator, not the cooperative. The cooperative establishes policy for the Euroclear System on behalf of Euroclear participants. Euroclear participants include banks (including central banks), securities brokers and dealers and other professional financial intermediaries and may include the underwriters. Indirect access to the Euroclear System is also available to other firms that clear through or maintain a custodial relationship with a Euroclear participant, either directly or indirectly. Euroclear is an

indirect participant in DTC. Distributions with respect to Bonds held beneficially through Euroclear will be credited to the cash accounts of Euroclear participants in accordance with the Euroclear terms and conditions, to the extent received by the Euroclear Bank and by Euroclear.

The Terms and Conditions Governing Use of Euroclear and the related Operating Procedures of the Euroclear System and applicable Belgian law govern securities clearance accounts and cash accounts with the Euroclear Operator. Specifically, these terms and conditions govern:

- Transfers of securities and cash within the Euroclear System;
- Withdrawal of securities and cash from the Euroclear System; and
- Receipts of payments with respect to securities in the Euroclear System.

All securities in the Euroclear System are held on a fungible basis without attribution of specific certificates to specific securities clearance accounts. The Euroclear Operator acts under the terms and conditions only on behalf of Euroclear participants and has no record of or relationship with persons holding securities through Euroclear participants.

Euroclear further advises that investors that acquire, hold and transfer interests in the notes by book-entry through accounts with the Euroclear Operator or any other securities intermediary are subject to the laws and contractual provisions governing their relationship with their intermediary, as well as the laws and contractual provisions governing the relationship between such an intermediary and each other intermediary, if any, standing between themselves and the notes.

The Euroclear Operator advises that under Belgian law, investors that are credited with securities on the records of the Euroclear Operator have a co-property right in the fungible pool of interests in securities on deposit with the Euroclear Operator in an amount equal to the amount of interests in securities credited to their accounts. In the event of the insolvency of the Euroclear Operator, Euroclear participants would have a right under Belgian law to the return of the amount and type of interests in securities credited to their accounts with the Euroclear Operator. If the Euroclear Operator did not have a sufficient amount of interests in securities on deposit of a particular type to cover the claims of all Euroclear participants credited with such interests in securities on the Euroclear Operator's records, all Euroclear participants having an amount of interests in securities of such type credited to their accounts with the Euroclear Operator would have the right under Belgian law to the return of their pro rata share of the amount of interest in securities actually on deposit.

Under Belgian law, the Euroclear Operator is required to pass on the benefits of ownership in any interests in securities on deposit with it, such as dividends, voting rights and other entitlements, to any person credited with such interests in securities on its records.

**Transfers Within and Among Book-Entry Systems**

Transfers between DTC's direct participants will occur in accordance with DTC rules. Transfers between Clearstream, Luxembourg customers and Euroclear participants will occur in accordance with its applicable rules and operating procedures.

DTC will effect cross-market transfers between persons holding directly or indirectly through DTC, on the one hand, and directly or indirectly through Clearstream, Luxembourg customers or Euroclear participants, on the other hand, in accordance with DTC rules on behalf of the relevant European international clearing system by its depositary. However, cross-market transactions will require

delivery of instructions to the relevant European international clearing system by the counterparty in that system in accordance with its rules and procedures and within its established deadlines (European time). The relevant European international clearing system will, if the transaction meets its settlement requirements, instruct its depositary to effect final settlement on its behalf by delivering or receiving securities in DTC, and making or receiving payment in accordance with normal procedures for same-day funds settlement applicable to DTC. Clearstream, Luxembourg customers and Euroclear participants may not deliver instructions directly to the depositaries.

Because of time-zone differences, credits of securities received in Clearstream, Luxembourg or Euroclear resulting from a transaction with a DTC direct participant will be made during the subsequent securities settlement processing, dated the business day following the DTC settlement date. Those credits or any transactions in those securities settled during that processing will be reported to the relevant Clearstream, Luxembourg customer or Euroclear participant on that business day. Cash received in Clearstream, Luxembourg or Euroclear as a result of sales of securities by or through a Clearstream, Luxembourg customer or a Euroclear participant to a DTC direct participant will be received with value on the DTC settlement date but will be available in the relevant Clearstream, Luxembourg or Euroclear cash amount only as of the business day following settlement in DTC.

Although DTC, Clearstream, Luxembourg and Euroclear have agreed to the foregoing procedures in order to facilitate transfers of notes among their respective participants, they are under no obligation to perform or continue to perform such procedures and such procedures may be discontinued at any time.

**Same-Day Settlement and Payment**

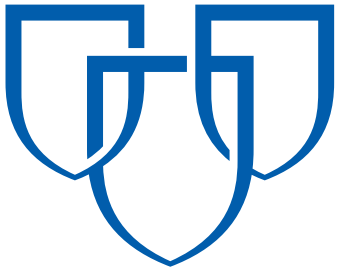
Secondary market trading between DTC direct participants will occur in accordance with DTC rules and will be settled in immediately available funds using DTC's Same-Day Funds Settlement System. Secondary market trading between Clearstream, Luxembourg customers and Euroclear participants will occur in accordance with their respective applicable rules and operating procedures and will be settled using the procedures applicable to conventional eurobonds in immediately available funds. No assurance can be given as to the effect, if any, of settlement in immediately available funds on trading activity (if any) in the notes.

MAYO CLINIC, THE UNDERWRITERS AND THE TRUSTEE CANNOT AND DO NOT GIVE ANY ASSURANCES THAT DTC, DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS OF DTC, CLEARSTREAM, CLEARSTREAM CUSTOMERS, EUROCLEAR OR EUROCLEAR PARTICIPANTS WILL DISTRIBUTE TO THE BENEFICIAL OWNERS OF THE BONDS (1) PAYMENTS OF PRINCIPAL OF OR INTEREST OR REDEMPTION PREMIUM ON THE BONDS; (2) CONFIRMATIONS OF THEIR OWNERSHIP INTERESTS IN THE BONDS; OR (3) OTHER NOTICES SENT TO DTC OR CEDE & CO., ITS PARTNERSHIP NOMINEE, AS THE REGISTERED OWNER OF THE BONDS, OR THAT THEY WILL DO SO ON A TIMELY BASIS, OR THAT DTC DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS, CLEARSTREAM, CLEARSTREAM CUSTOMERS, EUROCLEAR OR EUROCLEAR PARTICIPANTS WILL SERVE AND ACT IN THE MANNER DESCRIBED IN THIS OFFERING MEMORANDUM.

MAYO CLINIC, THE UNDERWRITERS AND THE TRUSTEE WILL NOT HAVE ANY RESPONSIBILITY OR OBLIGATIONS TO DTC, THE DIRECT PARTICIPANTS, THE INDIRECT PARTICIPANTS OF DTC CLEARSTREAM, CLEARSTREAM CUSTOMERS, EUROCLEAR, EUROCLEAR PARTICIPANTS OR THE BENEFICIAL OWNERS WITH RESPECT TO (1) THE ACCURACY OF ANY RECORDS MAINTAINED BY DTC OR ANY DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS OF DTC, CLEARSTREAM, CLEARSTREAM CUSTOMERS, EUROCLEAR OR EUROCLEAR PARTICIPANTS; (2) THE PAYMENT BY DTC OR ANY DIRECT

PARTICIPANTS OR INDIRECT PARTICIPANTS OF DTC, CLEARSTREAM, CLEARSTREAM CUSTOMERS, EUROCLEAR OR EUROCLEAR PARTICIPANTS OF ANY AMOUNT DUE TO ANY BENEFICIAL OWNER IN RESPECT OF THE PRINCIPAL AMOUNT OF OR INTEREST OR REDEMPTION PRICE ON THE BONDS; (3) THE DELIVERY BY DTC OR ANY DIRECT PARTICIPANTS OR INDIRECT PARTICIPANTS OF DTC, CLEARSTREAM, CLEARSTREAM CUSTOMERS, EUROCLEAR OR EUROCLEAR PARTICIPANTS OF ANY NOTICE TO ANY BENEFICIAL OWNER THAT IS REQUIRED OR PERMITTED TO BE GIVEN TO OWNERS UNDER THE TERMS OF THE INDENTURE; OR (4) ANY CONSENT GIVEN OR OTHER ACTION TAKEN BY DTC AS THE HOLDER OF THE BONDS.

MAYO CLINIC





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