Consolidated Financial Statements and Supplementary Information

The Cooper Health System
Years Ended December 31, 2017 and 2016
With Report of Independent Auditors

Ernst & Young LLP

Building a better working world

The Cooper Health System

Consolidated Financial Statements
and Supplementary Information

Years Ended December 31, 2017 and 2016

Contents

Ernst & Young LLP
99 Wood Avenue South
Metropark
P.O. Box 751
Iselin, NJ 08830-0471

Tel: +1 732 516 4200
Fax: +1 732 516 4429
ey.com

Report of Independent Auditors

Board of Trustees
The Cooper Health System

We have audited the accompanying consolidated financial statements of The Cooper Health System, which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations and changes in net assets 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 financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

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

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

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of The Cooper Health System at December 31, 2017 and 2016, and the consolidated results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheet as of December 31, 2017, and consolidating statement of operations and changes in net assets for the year then ended, are presented for purposes of additional analysis and are 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. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

April 25, 2018

The Cooper Health System

Consolidated Balance Sheets
(In Thousands)

	December 31	
	2017	**2016**
Assets		
Current assets:		
Cash and cash equivalents	**$ 229,850**	$ 198,314
Current portion of assets limited as to use	**36,695**	22,001
Patient accounts receivable, net of allowance for doubtful accounts of $47,305 and $32,483 in 2017 and 2016, respectively	**158,146**	173,484
Prepaid expenses and other current assets	**46,761**	49,788
Total current assets	**471,452**	443,587
Assets limited as to use:		
Internally designated by Board of Trustees	**233,675**	219,337
Externally designated for donor purposes	**47,403**	42,218
Externally designated under debt agreements, net of current portion	**3,761**	4,258
Designated under self-insurance programs, net of current portion	**29,243**	30,244
Assets limited as to use, net of current portion	**314,082**	296,057
Property, plant, and equipment, net	**503,718**	504,993
Other assets, net	**4,790**	7,009
Note receivable	**15,781**	15,781
Total assets	**$ 1,309,823**	$ 1,267,427

	December 31	
	2017	**2016**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 30,117**	$ 37,883
Accrued expenses	**118,334**	102,053
Current portion of estimated settlements due to third-party payors	**484**	2,158
Current portion of self-insured reserves	**19,834**	17,481
Current portion of long-term debt	**7,501**	9,534
Total current liabilities	**176,270**	169,109
Estimated settlements due to third-party payors, net of current portion	**8,012**	6,848
Accrued retirement benefits	**19,646**	15,073
Self-insured reserves, net of current portion	**55,079**	54,183
Long-term debt, net of current portion	**294,333**	303,009
Deferred revenue and other liabilities	**16,535**	12,737
Notes payable	**22,296**	22,296
Total liabilities	**592,171**	583,255
Net assets:		
Unrestricted	**683,283**	653,875
Temporarily restricted	**31,905**	27,834
Permanently restricted	**2,464**	2,463
Total net assets	**717,652**	684,172
Total liabilities and net assets	**$ 1,309,823**	$ 1,267,427

See accompanying notes.

The Cooper Health System

Consolidated Statements of Operations and Changes in Net Assets
(In Thousands)

	Year Ended December 31	
	2017	**2016**
Unrestricted net assets		
Revenue:		
Net patient service revenue	**$ 1,205,304**	$ 1,149,206
Provision for bad debts	**(84,695)**	(69,753)
Net patient service revenue less provision for bad debts	**1,120,609**	1,079,453
Other revenue	**76,830**	93,455
Total revenue	**1,197,439**	1,172,908
Expenses:		
Salaries, wages, and fringe benefits	**714,600**	674,772
Supplies and other	**402,680**	372,973
Malpractice	**17,892**	15,023
Depreciation and amortization	**48,561**	42,369
Interest	**14,138**	13,011
Total expenses	**1,197,871**	1,118,148
Operating (loss) income	**(432)**	54,760
Nonoperating gains and losses:		
Transaction-related costs	**(2,608)**	–
Investment return	**13,819**	5,529
Net change in unrealized gains and losses on trading securities	**6,811**	10,818
Gain (loss) on fixed asset disposal	**890**	(82)
Loss on extinguishment of debt	**–**	(615)
Gain on forgiveness of note payable	**–**	4,817
Change in value of equity method investments	**289**	(5,668)
Change in fair value of interest rate swap agreements	**445**	923
Excess of revenue over expenses	**19,214**	70,482
Other changes in unrestricted net assets:		
Change in pension benefit obligation	**(1,476)**	126
Contributions for capital acquisitions	**10,144**	14,418
Net change in unrealized gains and losses on other-than-trading securities	**1,526**	(143)
Increase in unrestricted net assets	**29,408**	84,883

The Cooper Health System

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

	Year Ended December 31	
	2017	**2016**
Temporarily restricted net assets		
Contributions, gifts, and special events, net of fundraising expense	**$ 5,784**	$ 6,381
Income from investments	**515**	452
Net realized and unrealized gains on investments	**564**	246
Net assets released from restrictions for operating purposes	**(2,792)**	(6,571)
Increase in temporarily restricted net assets	**4,071**	508
Permanently restricted net assets		
Net change in unrealized gains and losses on investments	**1**	1
Increase in permanently restricted net assets	**1**	1
Increase in net assets	**33,480**	85,392
Net assets, at beginning of year	**684,172**	598,780
Net assets, at end of year	**$ 717,652**	$ 684,172

See accompanying notes.

The Cooper Health System

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended December 31 2017	2016
Operating activities		
Increase in net assets	**$ 33,480**	$ 85,392
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Change in pension benefit obligation	**1,476**	(126)
Loss on extinguishment of debt	**–**	615
Gain on forgiveness of note payable	**–**	(4,817)
Change in fair value of interest rate swap agreements	**(445)**	(923)
Depreciation and amortization	**48,561**	42,369
(Gain) loss on property, plant, and equipment disposal	**(890)**	82
Provision for bad debts	**84,695**	69,753
Net realized and unrealized gains and losses on investments	**(14,498)**	(8,622)
Change in value of equity method investments	**(289)**	5,668
Contributions for capital acquisitions	**(10,144)**	(14,418)
Changes in certain assets and liabilities:		
Patient accounts receivable	**(69,357)**	(115,032)
Prepaid expenses and other assets	**5,535**	(547)
Accounts payable and accrued expenses	**8,515**	17,352
Self-insured reserves and accrued retirement benefits	**6,346**	8,774
Estimated settlements with third-party payors	**(510)**	(3,283)
Deferred revenue and other liabilities	**4,243**	(2,393)
Net cash provided by operating activities	**96,718**	79,844
Investing activities		
(Purchases) sales of assets limited as to use	**(18,221)**	6,290
Capital expenditures, net	**(47,507)**	(76,271)
Net cash used in investing activities	**(65,728)**	(69,981)
Financing activities		
Proceeds from issuance of long-term debt	**–**	45,796
Repayments of long-term debt	**(9,598)**	(21,249)
Contributions for capital acquisitions	**10,144**	14,418
Net cash provided by financing activities	**546**	38,965
Net increase in cash and cash equivalents	**31,536**	48,828
Cash and cash equivalents at beginning of year	**198,314**	149,486
Cash and cash equivalents at end of year	**$ 229,850**	$ 198,314
Supplemental disclosure of cash flow information		
Cash paid for interest	**$ 15,393**	$ 14,682

See accompanying notes.

The Cooper Health System

Notes to Consolidated Financial Statements
(Dollars in Thousands)

December 31, 2017

1. Organization

The Cooper Health System (Health System) is a New Jersey not-for-profit organization. The Health System is comprised of two operating divisions: The Cooper University Hospital (CUH) and Cooper University Physicians (UP). The CUH division includes the operations of Cooper Hospital/University Medical Center and The Children's Regional Hospital at Cooper, as well as programs focusing on ambulatory diagnostic and treatment services, wellness and prevention, and many other health services. The UP division consists primarily of the services provided by the employed medical staff.

The Health System also controls certain other entities which are included in the accompanying consolidated financial statements. Such entities include The Cooper Cancer Center (CCC); Cooper HealthCare Services, Inc. (CHCS); Cooper Medical Services, Inc. (CMS); and The Cooper Foundation (the Foundation). CCC owns and operates the cancer building which is leased to CUH. CHCS is a holding company, which is the sole shareholder of Cooper HealthCare Properties, Inc. (CHCP) and C&H Collection Services (C&H). CHCP manages a number of medical office buildings for the Health System, and C&H provides collection services primarily to the Health System. CMS owns and manages a medical office building on the campus of the Health System. The Health System appoints all of the members of the Board of Trustees and exercises certain control over the Foundation, which promotes the charitable, scientific, and educational programs and policies of the Health System.

In July 2016, the Health System entered into a service agreement with All Care Health Alliance, LLC (ACO), a New Jersey limited liability company participating in the Medicare Shared Saving Program, coordinated care, shared savings, bundled payment, and other similar programs or initiatives with or implemented by government payors. The Health System is the sole member of ACO. There was no activity for ACO during 2016 or 2017.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Health System and its controlled affiliates and subsidiaries as described above. All significant intercompany balances and transactions have been eliminated in consolidation.

2. Summary of Significant Accounting Policies (continued)

The entities comprising the Health System provide various inter-entity services to their affiliated entities and the Health System parent company. The services consist of certain financial planning, general accounting, and other management services. Charges for such services are based on the approximate cost to provide the services and are allocated between the entities based on an agreed-upon method which reflects the approximate level of usage by each entity.

Use of Estimates

The preparation of these consolidated financial statements in conformity with U.S. generally accepted accounting principles has required management to make estimates and assumptions that affect the reported amounts of assets, such as estimates affecting patient accounts receivable, and liabilities, such as estimated settlements due to third-party payors, self-insured reserves, and accrued retirement benefits, and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the amounts of revenues and expenses reported during the period. Actual results could differ from those estimates.

Charity Care

The Health System has a policy of providing charity care to patients who are unable to pay based on federal poverty income guidelines. All charity care patients are separately identified and related charges are reduced based on financial information obtained from the patient. Since management does not expect payment for charity care, the charges are excluded from net patient service revenue.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under payment agreements with third-party payors. Retroactive adjustments are recorded on an estimated basis in the period that the related services are rendered, and are adjusted in future periods as adjustments become known or as final settlements are determined. The methods for making these estimates and establishing the resulting amounts are continually reviewed and updated, with any resulting adjustments reflected in operating income.

2. Summary of Significant Accounting Policies (continued)

Advertising Costs

The Health System expenses advertising cost as incurred. In 2017 and 2016, the Health System incurred advertising expenses of $5,493 and $5,013, respectively, which are included in supplies and other expense on the consolidated statements of operations and changes in net assets.

Cash and Cash Equivalents

Cash and cash equivalents include various checking and savings accounts and all short-term funds, with initial maturity dates of three months or less, held on deposit with various lending institutions, excluding those classified as assets limited as to use. The Health System does not hold any money market funds with significant liquidity restrictions that would be required to be excluded from cash equivalents.

Patient Accounts Receivable

Patient accounts receivable for which the Health System receives payment under prospective payment formulae, negotiated rates, or cost reimbursement, which cover the majority of patient services, are stated at the estimated net amount receivable from such payors, which are generally less than the established billing rates of the Health System.

The Health System provides an allowance for doubtful accounts for estimated losses resulting from the unwillingness of patients to make payments for services. The allowance is determined by analyzing historical data and trends. Additions to the allowance for doubtful accounts result from the provision for bad debts. Accounts receivable are charged off against the allowance for doubtful accounts when management determines that recovery is unlikely and the Health System ceases collection efforts.

Supplies

Supplies, used in the provision of patient care, are stated at the lower of cost or net realizable value, determined by the average cost valuation method and are included in prepaid expenses and other current assets on the consolidated balance sheets.

2. Summary of Significant Accounting Policies (continued)

Derivative Financial Instruments

The Health System maintains interest rate swap agreements to mitigate the Health System's cash flow risk relating to changes in the variable interest rates of its Series 2008A and 2009A Bonds. Under the swap agreements, the Health System pays interest at fixed rates and receives interest at variable rates. All swap agreements are recorded at fair value on the accompanying consolidated balance sheets within deferred revenue and other liabilities. The net changes in the fair value of these swap agreements are recorded in nonoperating gains and losses on the accompanying consolidated statements of operations and changes in net assets, and the net monthly cash exchange under the contract is reflected within interest expense. In May 2016, the 2009A Bond interest rate swap agreement expired.

Fair Value of Financial Instruments

Financial instruments consist of cash equivalents, patient accounts receivable, assets limited as to use, notes receivable, accounts payable and accrued expenses, interest rate swaps, notes payable, and long-term debt. The carrying amounts reported on the accompanying consolidated balance sheets for cash equivalents, patient accounts receivable, notes receivable, accounts payable and accrued expenses, and notes payable approximate fair value. Management's estimate of the fair value of other financial instruments is described elsewhere in the notes to the consolidated financial statements.

Assets Limited as to Use and Investment Income

Assets limited as to use include internally designated assets set aside by the Board of Trustees (the Board), externally designated assets held in escrow (see Note 11) and held by trustees under debt agreements (includes debt service interest, principal, and reserve funds and funds for future capital expenditures), for self-insurance programs (includes trusts for workers' compensation and for medical professional and general liability), and funds designated as such for donor restrictions. Amounts set aside by the Board are designated for operations, future capital improvements, and other contingencies, as needed. The Board retains control over the internally designated assets and may, at its discretion, subsequently use such assets for other purposes.

2. Summary of Significant Accounting Policies (continued)

Amounts internally designated by the Board and externally designated by donors are classified as trading securities and all other assets limited as to use are deemed to be other than trading. Amounts required to meet current liabilities of the Health System have been classified as current assets in the consolidated financial statements.

Assets limited as to use consist of marketable securities and alternative investments. Marketable securities are carried at fair value based on quoted market prices. Alternative investments consist of an interest in a fund of funds, structured as a limited partnership. Investment return, net of amounts capitalized, from assets limited as to use, consisting of interest and dividend income and realized gains and losses, and the change in unrealized gains and losses on trading securities, including equity in income on alternative investments, are presented as nonoperating gains and losses. The net change in unrealized gains and losses on investments which are classified as other-than-trading securities is reported as a separate component of the change in unrestricted net assets.

Alternative investments (nontraditional, not readily marketable asset classes), which are structured such that the Health System holds limited partnership interests, are reported on the accompanying consolidated balance sheets based upon net asset values derived from the application of the equity method of accounting. Generally, net asset value reflects net contributions to the investee and an ownership share of realized and unrealized investment income and expenses. Individual investment holdings in alternative investments of the Health System may, in turn, include investments in both marketable and nonmarketable securities. Valuations of these alternative investments and, therefore, the Health System's holdings, may be determined by the investment manager or general partner. Values may be based on historical cost appraisals or other estimates that require varying degrees of judgment. The Health System uses the latest available information to value these alternative investments. The alternative investments may indirectly expose the Health System to securities lending; short sales of securities; and trading in futures and forward contracts, options, and other derivative products. Alternative investments also have liquidity restrictions under which the Health System's capital may be divested only at specified times.

Financial information used to evaluate the alternative investments is provided by the investment manager or general partner and includes fair value valuations (quoted market prices and values determined through other means) of underlying securities and other financial instruments held by the investee and estimates that require varying degrees of judgment. The financial statements of the investees are audited annually by independent auditors, although the timing for reporting the results of such audits does not coincide with the Health System's financial statement reporting.

2. Summary of Significant Accounting Policies (continued)

The Health System also retains the services of an independent investment consultant to provide specialized investment oversight. There is uncertainty in the accounting for alternative investments arising from factors such as lack of active markets (primary and secondary), lack of transparency into underlying holdings, and time lags associated with reporting by the investee companies. As a result, there is at least a reasonable possibility that estimates will change by material amounts in the near term.

Property, Plant, and Equipment

Property, plant, and equipment that were purchased are recorded at cost. Contributed assets are recorded at fair value at the date of donation. Depreciation is provided over the estimated useful lives of the assets of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized using the straight-line method over the lesser of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest costs incurred on borrowed funds, net of related interest income during the period of construction of capital assets, is capitalized as a component of acquiring the assets. The Health System capitalized net interest expense of $1,142 and $1,606 for the years ended December 31, 2017 and 2016, respectively.

Gifts or grants for the purchase of long-lived assets such as land, buildings, or equipment are excluded from the excess of revenue over expenses. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Health System continually evaluates whether later events and circumstances have occurred that indicate the remaining estimated useful life of long-lived assets may warrant revision or that the remaining balance may not be recoverable. When factors indicate that long-lived assets should be evaluated for possible impairment, the Health System uses an estimate of the related undiscounted operating income over the remaining life of the long-lived asset, or determines the fair value of the long-lived asset in measuring whether the long-lived asset is recoverable. Management believes that no revision to the remaining useful lives or write-down of long-lived assets was required as of December 31, 2017 or 2016.

2. Summary of Significant Accounting Policies (continued)

Self-Insured Reserves

The Health System is self-insured for the majority of its risks resulting from medical malpractice, employee health, general liability, and the first layer of workers' compensation. A portion of the losses are covered with high-deductible commercial insurance policies and through trust funds. The Health System accrued liabilities which include estimates of the ultimate costs for both reported claims and claims incurred but not reported for each of their risks.

Excess of Revenue Over Expenses

The accompanying consolidated statements of operations and changes in net assets include the excess of revenue over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the excess of revenue over expenses include net change in unrealized gains and losses on investments designated as other-than-trading securities to the extent such losses are considered temporary, other changes in pension benefit obligation, and contributions of long-lived assets (including assets acquired using donor-restricted contributions or grant funds that were to be used for the purposes of acquiring such assets). Transactions deemed by management to be ongoing, major, or central to the provision of health care services are reported as revenue and expenses and included within operating (loss) income.

Classification of Net Assets

The Health System separately accounts for and reports donor-restricted and unrestricted net assets. Unrestricted net assets are not externally restricted for identified purposes by donors or grantors. Unrestricted net assets include resources that the governing board may use for any designated purpose and resources whose use is limited by agreement between the Health System and an outside party other than the donor or grantor.

Temporarily restricted net assets are those whose use by the Health System has been limited by donors to a specific time period or purpose. As the donors' intentions are met or a time restriction expires, the net assets are reclassified to unrestricted and reported on the consolidated statements of operations and changes in net assets as other revenue.

Permanently restricted net assets have been restricted by donors to be maintained by the Health System in perpetuity. As specified by donors, the income earned on these investments is expendable to support patient care services.

2. Summary of Significant Accounting Policies (continued)

Income Taxes

The Health System, CCC, CMS, and the Foundation are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal and state income taxes on related income pursuant to Section 501(a) of the Code and the laws of the state of New Jersey. CHCS is a for-profit entity and, as such, is subject to federal and state income taxes. The provision for income taxes is not material to the Health System's consolidated results of operations.

As a result of the recent federal income tax reform enacted into law under the Tax Cuts and Jobs Act of 2017, certain provisions will impact tax-exempt organizations, including revisions to taxes on unrelated business activities, excise taxes on compensation of certain employees, and various other provisions. The regulations necessary to implement the law are expected to be promulgated throughout 2018 and the ultimate outcome of these regulations and the impact to the Health System cannot be determined presently.

Reclassifications

Certain reclassifications have been made to the 2016 amounts previously reported in order to conform to the current year presentation. These reclassifications had no impact on the previously reported net assets.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*. The core principle of ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The guidance in ASU 2014-09 supersedes the FASB's current revenue recognition requirements in Accounting Standards Codification (ASC) 605, *Revenue Recognition*, and most industry-specific guidance. The FASB subsequently issued ASU 2015-14, *Revenue from Contracts with Customers*, which deferred the effective dates of ASU 2014-09. Based on ASU 2015-04, the provisions of ASU 2014-09 are effective for the Health System for fiscal years beginning after December 15, 2017, and interim periods within that fiscal year. The Health System plans to adopt ASU 2014-09 following the modified retrospective

2. Summary of Significant Accounting Policies (continued)

approach of application. Subsequent to adoption, certain patient activity where collection is uncertain, which was previously reported on the Health System's consolidated statements of operations and changes in net assets as net patient service revenue with a corresponding provision for bad debts, will no longer meet the criteria for revenue recognition and, accordingly, the provision for bad debts after the adoption date will be significantly reduced with a corresponding reduction to net patient service revenue. Such patient activity will be classified as an implicit price concession. Additionally, the provision for bad debts will be presented as an expense item rather than a reduction to net patient service revenue. The Health System's adoption of ASU 2014-09 will have other impacts to net patient service revenue, which include judgments regarding collection analyses applied at the time services are rendered and estimates of variable consideration and the addition of certain qualitative and quantitative disclosures. The Health System continues to assess the impact of the adoption of ASU 2014-09 in relation to other revenue activity, as applicable; however, other revenue is less significant to the Health System's consolidated statements of operations and changes in net assets.

In May 2015, the FASB issued ASU 2015-07, *Fair Value Measurement: Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*. ASU 2015-07 removes the requirement to categorize within the fair value hierarchy investments for which fair values are estimated using the net asset value practical expedient provided by ASC 820, *Fair Value Measurement*. Disclosures about investments in certain entities that calculate net asset value per share are limited under ASU 2015-07 to those investments for which the entity has elected to estimate the fair value using the net asset value practical expedient. ASU 2015-07 is effective for entities (other than public business entities) for fiscal years beginning after December 15, 2016, with retrospective application to all periods presented. Early application is permitted. The Health System adopted the standard in 2017 and the adoption had no impact on its consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall: Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU 2016-01 will require business-oriented health care not-for-profit entities to measure equity investments that do not result in consolidation and are not accounted for under the equity method at fair value and recognize any changes in fair value in the performance indicator unless the investments qualify for a new practicality exception. The practicality exception is available for equity investments without a readily determinable fair value, for which measurement would be based on cost less impairment and adjusted for observable price changes. Subsequent to the adoption of ASU 2016-01, the Health

2. Summary of Significant Accounting Policies (continued)

System will no longer be able to recognize unrealized holding gains and losses on equity securities currently classified as other-than-trading outside of the performance indicator. This ASU does not impact the accounting for investments in debt securities. The guidance is effective for annual periods beginning after December 15, 2018. Early adoption is permitted for annual periods beginning after December 15, 2017. The Health System has not completed the process of evaluating the impact of ASU 2016-01 on its consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases*, which will require a lessee to report most leases on its balance sheet but recognize expenses on its income statement in a manner similar to current accounting. The guidance also eliminates current real estate-specific provisions. The provisions of ASU 2016-02 are effective for the Health System for annual periods beginning after December 15, 2018, and interim periods within those years. Early adoption is permitted. The Health System has not completed the process of evaluating the impact of ASU 2016-02 on its consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, which eliminates the requirement for not-for-profits (NFPs) to classify net assets as unrestricted, temporarily restricted, and permanently restricted. Instead, NFPs will be required to classify net assets as net assets with donor restrictions or without donor restrictions. Entities that use the direct method of presenting operating cash flows will no longer be required to provide a reconciliation of the change in net assets to operating cash flows. The guidance also modifies required disclosures and reporting related to net assets, investment expenses, and qualitative information regarding liquidity. NFPs will also be required to report all expenses by both functional and natural classification in one location. The provisions of ASU 2016-14 are effective for the Health System for annual periods beginning after December 15, 2017, and interim periods thereafter. Early adoption is permitted. The Health System has not completed the process of evaluating the impact of ASU 2016-14 on its consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows: Classification of Certain Cash Receipts and Cash Payments*, which addresses the following eight specific cash flow issues in order to limit diversity in practice: debt prepayment or debt extinguishment costs; settlement of zero-coupon debt instruments or other debt instruments with coupon interest rates that are insignificant in relation to the effective interest rate of the borrowing; contingent consideration payments made after a business combination; proceeds from the settlement of

2. Summary of Significant Accounting Policies (continued)

insurance claims; proceeds from the settlement of corporate-owned life insurance policies, including bank-owned life insurance policies; distributions received from equity method investees; beneficial interests in securitization transactions; and separately identifiable cash flows and application of the predominance principle. The provisions of ASU 2016-15 are effective for the Health System for annual periods beginning after December 15, 2018, and interim periods thereafter. Early adoption is permitted. The Health System has not completed the process of evaluating the impact of ASU 2016-15 on its consolidated financial statements.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows: Restricted Cash*, which requires that the statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The provisions of ASU 2016-18 are effective for the Health System for annual periods beginning after December 15, 2018, and interim periods thereafter. Early adoption is permitted. The Health System has not completed the process of evaluating the impact of ASU 2016-18 on its consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits: Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. ASU 2017-07 addresses how employers that sponsor defined benefit pension and/or other postretirement benefit plans present the net periodic benefit cost on the income statement. Employers will be required to present the service cost component of net periodic benefit cost in the same income statement line item as other employee compensation costs arising from services rendered during the period. Employers will present the other components of the net periodic benefit cost separately from the line item that includes the service cost and outside of any subtotal of operating income, if one is presented. The standard is effective for the Health System for annual periods beginning after December 15, 2018, and interim periods within annual periods beginning after December 15, 2019. Early adoption is permitted. Adoption of ASU 2017-07 will require the Health System to include the service cost component of net periodic benefit cost related to its defined benefit plan ($1,580 and $1,440 for 2017 and 2016, respectively) within salaries, wages, and fringe benefits on the consolidated statements of operations and changes in net assets and to present all other components (aggregate of $1,516 and $1,794 for 2017 and 2016, respectively) as a separate line

2. Summary of Significant Accounting Policies (continued)

item excluded from the subtotal for operating income. Net periodic benefit cost is reported currently within salaries, wages, and fringe benefits on the consolidated statements of operations and changes in net assets.

3. Net Patient Service Revenue

The Health System's service area is southern New Jersey. The Health System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements.

The Health System has agreements with third-party payors that provide for payments at amounts different from established charges. The CUH's inpatient acute care services and the UP's professional services for Medicare and Medicaid program beneficiaries and the CUH's outpatient services for Medicare program beneficiaries are primarily paid at prospectively determined rates per discharge or visit or based upon fee schedules. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The Health System is reimbursed for CUH cost reimbursable and other pass-through items, such as bad debts and paramedical education, from Medicare and CUH outpatient services for Medicaid at tentative rates with final settlements determined after submission of annual cost reports by the Health System and audits thereof by the programs' fiscal intermediaries. Provisions for estimated adjustments resulting from audit and final settlements have been recorded. The Health System's cost reports through fiscal year 2009 and fiscal years 2011 through 2014 have been settled by Medicare. The cost reports for fiscal years 2010, 2015, and 2016 have been submitted. In the opinion of management, adequate provision has been made for any adjustment which may result from the final settlement of these reports, appeal items, or other retroactive changes. Differences between the estimated adjustments and the amounts settled are recorded in the year of settlement or as adjustments become known. In 2017 and 2016, the consolidated financial statements include revenue of $2,172 and $3,281, respectively, related to favorable adjustments of prior year cost reports.

Collectively, net revenues from the Medicare and Medicaid programs constitute approximately 53% and 50% of the Health System's net patient service revenue for the years ended December 31, 2017 and 2016, respectively.

3. Net Patient Service Revenue (continued)

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation, and noncompliance could subject the Health System to significant regulatory action, including fines and penalties. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Health System believes that it is in compliance with applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential noncompliance that could have a material adverse effect on the accompanying consolidated financial statements. Compliance with such laws and regulations can be subject to future government review and interpretations as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs. The Health System has a corporate compliance program to monitor compliance with Medicare and Medicaid laws and regulations.

There are various proposals at the federal and state levels that could, among other things, significantly reduce payment rates or modify payment methods. The ultimate outcome of these proposals and other market changes, including the potential effects of or revisions to health care reform that has been enacted by the federal and state governments cannot presently be determined. Future changes in the Medicare and Medicaid programs and any reduction of funding could have an adverse impact on the Health System. Additionally, certain payors' payment rates for various years have been appealed by the Health System. If the appeals are successful, additional income applicable to those years might be realized.

The Health System has also entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Health System under these agreements includes prospectively determined rates per discharge or visit, discounts from established charges, and prospectively determined daily rates. These agreements have retrospective audit clauses allowing the payor to review and adjust claims subsequent to initial payment.

The Health System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of the contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Health System recognizes revenue on the basis of discounted rates for services provided in accordance with the Health System's policy and state regulation. On the basis of historical experience, a significant portion of the Health System's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Health System records a significant provision for bad debts related to uninsured patients.

3. Net Patient Service Revenue (continued)

Accounts receivable are reduced by an allowance for doubtful accounts. The Health System's allowance for doubtful accounts totaled $47,305 and $32,483 at December 31, 2017 and 2016, respectively. In evaluating the collectibility of accounts receivable, the Health System 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 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 payor coverage, the Health System analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients, the Health System records a significant provision for bad debts 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 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.

Effective November 1, 2016, the Health System finalized the implementation of an integrated electronic medical record and patient billing system. As a result of implementation issues and billing and collection delays, certain patient accounts receivable balances recorded in 2016 and 2017 were determined to be uncollectible and the Health System recorded a reduction in October 2017 to the net patient account receivable balance comprised of two components: a reduction to patient accounts receivable and net patient service revenue of approximately $13,600 was recorded related to receivable balances which existed at December 31, 2016; and a reduction to accounts receivable and net patient service revenue of approximately $17,400 was recorded in relation to patient services provided in 2017. The Health System has continued to enhance its revenue cycle implementation efforts throughout 2017 and re-evaluated its processes for recording contractual allowances and estimating the net accounts receivable balance as reported on the accompanying December 31, 2017 consolidated balance sheet.

(Dollars in Thousands)

3. Net Patient Service Revenue (continued)

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	Year Ended December 31	
	2017	**2016**
Third-party payors	**$ 1,190,143**	$ 1,131,521
Self-pay	**15,161**	17,685
Patient service revenue (net of contractual allowances and discounts)	**$ 1,205,304**	$ 1,149,206

Deductibles and copayments under third-party payment programs within third-party payor amounts above are the patients' responsibility and the Health System considers these amounts in its determination of the provision for bad debts based on collection experience.

The mix of net accounts receivable from patients and third-party payors was as follows:

	December 31	
	2017	**2016**
Commercial	**18%**	17%
Health maintenance organizations	**42**	44
Medicare	**22**	22
Blue Cross	**11**	12
Self-pay (including accounts which may ultimately be charity care)	**4**	2
Medicaid	**3**	3
	100%	100%

4. Charity Care and State Subsidies

The Health System provides care to those who meet the State of New Jersey Public Law 1992 (Chapter 160) charity care criteria. Charity care is provided without charge or at amounts less than its established charges. The Health System maintains records to identify and monitor the level of charity care it provides. The cost of services provided and supplies furnished under its charity care policy is estimated using internal cost data and is calculated based on the Health System's cost accounting system. The total direct and indirect amount of charity care provided, determined on the basis of cost, was $26,905 and $24,671 for the years ended December 31, 2017 and 2016, respectively.

The Health System's patient acceptance policy is based upon its mission statement and its charitable purposes. Accordingly, the Health System accepts all patients regardless of their ability to pay. This policy results in the Health System's assumption of significant patient receivable credit risks. To the extent that the Health System realizes additional losses resulting from such credit risks and patients that are not identified or do not meet the Health System's defined charity care policy, such additional losses are included in the provision for bad debts.

Chapter 160 established the Charity Care Subsidy Fund and the Hospital Relief Subsidy Fund to provide a mechanism and funding source to compensate certain hospitals for charity care and other services. These amounts are subject to change from year to year based on available state budget amounts and allocation methodologies.

Effective July 1, 2014, the state replaced the Hospital Relief Subsidy Fund with the Delivery System Reform Incentive Payment Pool (DSRIP). DSRIP is available to certain hospitals that are able to establish performance improvement activities in one of eight specified clinical improvement areas. CUH qualified under the Diabetes Long-Term Complications Admission Rate metric. DSRIP covers the period of July 1 to June 30 of each fiscal year. Following the initial project period, the subsidy can be adjusted positively or negatively depending on the performance during a fiscal period. Such adjustments are processed prospectively.

(Dollars in Thousands)

4. Charity Care and State Subsidies (continued)

The Health System recorded the following amounts from these sources as net patient service revenue:

	Year Ended December 31	
	2017	**2016**
Charity Care Subsidy Fund	**$ 16,759**	$ 26,680
Delivery System Reform Incentive Payment Pool	**7,180**	5,726
	$ 23,939	$ 32,406

5. Assets Limited as to Use and Investment Income

The composition of assets limited as to use, primarily at fair value, is as follows:

	December 31	
	2017	**2016**
Internally designated by Board of Trustees:		
Cash and cash equivalents	**$ 9,111**	$ 2,945
Equity securities:		
U.S. companies	**56,991**	61,623
International companies	**2,219**	2,327
U.S. Treasury securities	**17,965**	19,148
Governmental asset-backed securities	**–**	61
Mutual funds	**6,292**	4,975
Alternative investments, at equity method value	**10,665**	9,895
Corporate bonds	**130,432**	118,363
	$ 233,675	$ 219,337

(Dollars in Thousands)

5. Assets Limited as to Use and Investment Income (continued)

	December 31	
	2017	**2016**
Externally designated for donor purposes:		
Cash and cash equivalents	**$ 585**	$ 753
Equity securities:		
U.S. companies	**27,692**	25,078
International companies	**5**	6
Mutual funds	**–**	40
U.S. Treasury securities	**7,909**	4,402
Governmental asset-backed securities	**503**	11
Corporate bonds	**10,709**	11,928
	$ 47,403	$ 42,218
Externally designated – under debt agreements:		
Cash and cash equivalents	**$ 12,194**	$ 13,402
Less current portion	**8,433**	9,144
	$ 3,761	$ 4,258
Assets held under debt agreements are maintained for the following purposes:		
Debt service interest funds	**$ 4,049**	$ 4,137
Debt service principal funds	**4,384**	5,007
Debt service reserve funds	**257**	764
Capital addition funds	**3,504**	3,494
	$ 12,194	$ 13,402
Designated – under self-insurance programs:		
Cash and cash equivalents	**$ 3,684**	$ 573
Equity securities:		
U.S. companies	**10,640**	10,749
U.S. Treasury securities	**6,536**	6,330
Corporate bonds	**21,645**	25,449
	42,505	43,101
Less current portion	**13,262**	12,857
	$ 29,243	$ 30,244

(Dollars in Thousands)

5. Assets Limited as to Use and Investment Income (continued)

	December 31	
	2017	**2016**
Externally designated – escrow agreement *(Note 11)*:		
Cash equivalents – current	**$ 15,000**	$ –

Investment return, net of amounts capitalized, and net unrealized gains and losses on trading securities are included in nonoperating gains and losses and are comprised of the following:

	Year Ended December 31	
	2017	**2016**
Nonoperating gains and losses:		
Interest and dividend income	**$ 8,223**	$ 7,829
Net realized gains (losses) on sales of securities	**5,596**	(2,300)
Investment return	**13,819**	5,529
Change in net unrealized gains and losses on trading securities	**6,811**	10,818
	$ 20,630	$ 16,347

Changes in net unrealized gains and losses on other-than-trading securities totaled $1,526 and $(143) for the years ended December 31, 2017 and 2016, respectively.

The fair value framework establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include Level 1 – defined as observable inputs such as quoted prices in active markets; Level 2 – defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3 – defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

In determining fair value, the Health System uses the market approach. This approach utilizes prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities.

(Dollars in Thousands)

5. Assets Limited as to Use and Investment Income (continued)

The Health System records its alternative investments held within assets limited as to use based upon the equity method of accounting and, accordingly, such assets are excluded from the fair value table below.

The following table presents the fair value hierarchy for the Health System's financial assets measured at fair value on a recurring basis which include cash and cash equivalents, assets limited as to use (excluding alternative investments of $10,665 and $9,895 at December 31, 2017 and 2016, respectively), and the mark-to-market asset position of interest rate swap arrangements:

	Total	Level 1	Level 2	Level 3
December 31, 2017				
Assets				
Cash and cash equivalents	**$ 270,424**	**$ 270,424**	**$ –**	**$ –**
Equity securities:				
U.S. companies	**95,323**	**95,323**	**–**	**–**
International companies	**2,224**	**2,224**	**–**	**–**
Mutual funds	**6,292**	**6,292**	**–**	**–**
U.S. Treasury securities	**32,410**	**32,410**	**–**	**–**
Governmental asset-backed securities	**503**	**–**	**503**	**–**
Corporate bonds	**162,786**	**–**	**162,786**	**–**
Total assets measured at fair value	**$ 569,962**	**$ 406,673**	**$ 163,289**	**$ –**
Liabilities				
Interest rate swaps	**$ 3,720**	**$ –**	**$ 3,720**	**$ –**
Total liabilities measured at fair value	**$ 3,720**	**$ –**	**$ 3,720**	**$ –**

(Dollars in Thousands)

5. Assets Limited as to Use and Investment Income (continued)

	Total	Level 1	Level 2	Level 3
December 31, 2016				
Assets				
Cash and cash equivalents	$ 215,987	$ 215,987	$ –	$ –
Equity securities:				
U.S. companies	97,450	97,450	–	–
International companies	2,333	2,333	–	–
Mutual funds	5,015	5,015	–	–
U.S. Treasury securities	29,880	29,880	–	–
Governmental asset-backed securities	72	–	72	–
Corporate bonds	155,740	–	155,740	–
Total assets measured at fair value	$ 506,477	$ 350,665	$ 155,812	$ –
Liabilities				
Interest rate swaps	$ 4,165	$ –	$ 4,165	$ –
Total liabilities measured at fair value	$ 4,165	$ –	$ 4,165	$ –

The Health System determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

The Health System determines the estimated fair value for its Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, quoted prices for identical or similar assets in non-active markets (few transactions, limited information, noncurrent prices, high variability over time), inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves volatilities, default rates), and inputs that are derived principally from or corroborated by other observable market data.

(Dollars in Thousands)

6. Property, Plant, and Equipment

	December 31 2017	2016	Depreciable Life
Land	**$ 5,716**	$ 5,716	
Land improvements	**1,320**	1,320	5–25 years
Buildings and building improvements	**527,217**	504,030	10–40 years
Fixed equipment	**58,042**	57,486	10–20 years
Major movable equipment	**413,305**	376,698	5–20 years
	1,005,600	945,250	
Less accumulated depreciation	**(564,069)**	(514,374)	
	441,531	430,876	
Construction-in-progress	**62,187**	74,117	
	$ 503,718	$ 504,993	

Depreciation expense for the years ended December 31, 2017 and 2016 amounted to $49,672 and $43,740, respectively. Property, plant, and equipment, net included $6,202 and $7,093 of assets held under capitalized leases at December 31, 2017 and 2016, respectively.

The Health System sold certain property, plant, and equipment resulting in a gain on sale of $890 and loss of $82 for the years ended December 31, 2017 and 2016, respectively.

(Dollars in Thousands)

7. Long-Term Debt

	December 31 2017	2016
2008A New Jersey Economic Development Authority (NJEDA) Variable Rate Demand Revenue Bonds, with principal payments ranging from $1,800 to $13,500 due annually beginning on November 1, 2033 through 2038, with monthly interest payments, adjusted to a weekly rate determined by the remarketing agent, not to exceed 12% (0.39% and 0.19% at December 31, 2017 and 2016, respectively)	**$ 50,000**	$ 50,000
2009A Camden County Improvement Authority (CCIA) Variable Rate Revenue Bonds, with principal payments ranging from $73 to $76 due monthly on March 15 through February 15, 2021, with monthly interest payments based on 67% of London Interbank Offered Rate (LIBOR), plus 168 basis points	**3,337**	4,306
2013A CCIA Revenue Bonds, including unamortized original issue discount of $1,578 and $1,643 at December 31, 2017 and 2016, respectively, with principal payments ranging from $595 to $15,200 due annually beginning on November 1, 2035 through 2042, with interest rates ranging from 5.00% to 5.25%, due February 15 and August 15 of each year	**53,337**	53,272
2014A CCIA Revenue Bonds, including unamortized original issue premium of $14,442 and $15,983 at December 31, 2017 and 2016, respectively, with principal payments ranging from $4,100 to $10,690 due annually through 2035, with an interest rate of 5.00%, due February 15 and August 15 of each year	**145,392**	151,433
$997 capital lease, with principal and interest payments due monthly through 2018. Principal payments ranging from $15 to $16 plus a fixed interest rate of 5.30%	**103**	300
$2,496 equipment loan, with principal and interest payments due monthly through 2017	**–**	277
Note payable due in monthly installments, including interest adjusted every five years per the agreement (5.75% at December 31, 2017 and 2016), maturity date of July 1, 2023, secured by the building and substantially all assets of CHCP	**320**	369

(Dollars in Thousands)

7. Long-Term Debt (continued)

	December 31	
	2017	**2016**
$8,849 capital lease, with principal and interest payments due monthly through 2028. Principal payments ranging from $171 to $1,213	**$ 8,233**	$ 8,467
New Jersey Health Care Facilities Financing Authority Capital Asset Program; Series 2007A Capital Asset Program Loan, with monthly principal payments of $30 through October 1, 2017, with monthly interest payments based on variable rate which was 3.56% at December 31, 2016	**–**	2,029
2016 Mortgage Loan due in monthly installments of $220, including interest at 3.04%, through October 1, 2041	**44,453**	45,796
	305,175	316,249
Less current portion	**7,501**	9,534
Less deferred financing costs	**3,341**	3,706
Long-term debt, net of current portion	**$ 294,333**	$ 303,009

The outstanding balance of NJEDA 2008B Revenue Bonds of approximately $10,200 was paid off through a drawdown of the Health System's line of credit in March 2016. In September 2016, the outstanding balance on the line of credit and the 2002 Revenue Bonds were refinanced by CMS through a long-term mortgage obligation of $45,800 with a commercial bank, repayable over a period of 10 years with a 30-year amortization schedule and balloon payment at maturity. There was a loss of $615 on extinguishment of the 2002 Revenue Bonds. The remaining funds available from the 2016 loan (approximately $31,400 after repayment of the line of credit draw and payment of financing costs) were transferred to CUH as an intercompany loan between CMS and CUH.

Revenue Bonds

The Health System pays monthly debt service to the Bond Trustee to secure the 2009A, 2013A, and 2014A Revenue Bonds. The 2008A Revenue Bonds are enhanced by a letter of credit agreement from a bank, which expires on January 29, 2019, with renewal options as defined. Under a master trust indenture (MTI), the Health System granted to the Master Trustee a security interest in its gross receipts and a mortgage on the property of the Health System's main facility, as defined.

(Dollars in Thousands)

7. Long-Term Debt (continued)

The Health System must comply with MTI covenants, including requirements as to the permitted level of indebtedness, restrictions on the sale of certain assets, mergers, and other significant transactions, including a requirement that the Health System generate funds available for debt service equivalent to at least 125% of maximum annual debt service (all terms as defined in the MTI). In addition, the 2008A Revenue Bonds Letter of Credit Agreement requires the Health System to maintain minimum days cash on-hand, as defined. As of December 31, 2017 and 2016, the Health System has complied with these financial covenants.

Interest Rate Swap Agreements

The Health System has entered into interest rate swap agreements with the intent of mitigating cash flow risk relating to changes in the variable interest rates of the 2008A Bonds. Under the swap agreements, the Health System pays interest at fixed rates and receives interest at variable rates. The swaps settle on a monthly basis. The following schedule outlines the terms and fair values of the interest rate swap agreements that are included in deferred revenue and other liabilities on the accompanying consolidated balance sheets:

	Series 2008A	**Series 2008A**
Notional amount at December 31, 2017	$25,000	$25,000
Effective date	March 23, 2009	March 9, 2009
Termination date	November 1, 2029	November 1, 2029
Fixed rate	2.577%	2.428%
Variable rate basis	3-month USD-LIBOR-BBA	3-month USD-LIBOR-BBA
Fair value at December 31, 2017	$(2,028)	$(1,692)
Change in fair value for the year ended December 31, 2017	$ 235	$ 210

During 2017 and 2016, the fair value of the interest rate swaps exceeded the mark-to-market value set forth in the agreement requiring collateral to be posted. Total collateral posted totaled $570 and $2,330 at December 31, 2017 and 2016, respectively. These balances are included within prepaid expenses and other current assets on the consolidated balance sheets.

7. Long-Term Debt (continued)

Line of Credit

The Health System has revolving lines of credit for $5,000 and $15,000 with a bank at December 31, 2017 and 2016, respectively. The agreements provide for interest at 0.5% above the prime rate of interest per annum, but shall never be less than 5.5%. The current line of credit is available through December 31, 2018, and may be renewed for one-year extensions with the bank's consent. The line of credit contains a negative pledge of accounts receivable of the Health System, and requires the Health System to maintain a minimum debt service coverage ratio of 1.25, as defined in the agreement. At December 31, 2017, there was $1,837 outstanding under the line of credit (reported within accrued expenses). There were no amounts outstanding under the line of credit at December 31, 2016.

Fair Value

The Health System uses current quoted market prices for similar assets and other observable inputs (Level 2) in estimating the fair value of its fixed-rate revenue bonds. The carrying value of the variable rate demand bonds and other long-term obligations approximates fair value. The fair value of the Health System's long-term obligations, excluding the equipment loans and capital leases, was $298,590 and $305,372 with a carrying value of $296,839 and $305,176 at December 31, 2017 and 2016, respectively.

(Dollars in Thousands)

7. Long-Term Debt (continued)

Future Payments

Scheduled payments on long-term debt for the next five years and thereafter are as follows:

	Revenue Bonds and Mortgage Loan	Capital Leases	Note Payable	Total
2018	$ 6,993	$ 459	$ 49	$ 7,501
2019	7,410	408	56	7,874
2020	7,847	507	59	8,413
2021	7,332	631	63	8,026
2022	7,550	784	68	8,402
Thereafter	246,523	5,547	25	252,095
	283,655	8,336	320	292,311
Net unamortized original issue premium	12,864	–	–	12,864
	$ 296,519	$ 8,336	$ 320	$ 305,175

8. New Market Tax Credit Program

In January 2016, the Health System fulfilled its obligations under the 2008 New Market Tax Credit program and the note payable outstanding of approximately $4,800 was forgiven.

In October 2012, the Health System and The Cooper Cancer Center entered into transactions as part of the Federal New Market Tax Credit Program (the Program). Under the Program, a taxpayer may claim tax credits over a seven-year period with respect to a qualified equity investment in a qualified community development entity (CDE). An equity investment in a CDE is a qualified equity investment if substantially all of the cash provided is then used by the CDE to make qualified low-income community investments, which includes a loan to any qualified active low-income community business.

8. New Market Tax Credit Program (continued)

In conjunction with the Program, the Health System loaned $15,781 to a financial institution through a promissory note (the Note) to be used for qualified equity investments in several CDEs. Interest on the Note will accrue at 1.54% per annum with interest payments received quarterly. Principal payments are received quarterly beginning December 2019. At the end of the seven-year compliance period for the new market tax credits, the Health System has the option to call the Note for a nominal amount. The Note matures on July 1, 2039.

Also in October 2012, The Cooper Cancer Center entered into promissory note agreements (the Agreements) totaling $22,296 with third-party CDEs as part of the Program. The Cooper Cancer Center was structured to meet the definition of a qualified active low-income community business under the provisions of the Program. Interest payments on the Agreements are made quarterly and accrue at a fixed interest rate of 1.1% per annum. Principal payments are made quarterly by The Cooper Cancer Center beginning December 2019 through September 2042. At the end of the seven-year compliance period for the new market tax credits, approximately $6,515 of the outstanding balance of the Agreements is expected to be forgiven. The remaining $15,781 outstanding on the Agreements is offset by the Note owed to the Health System for purposes of cash flow. The carrying values of the Health System's Note and The Cooper Cancer Center's agreements approximate their fair value.

9. Pension Plans

Defined Contribution Plan

The Health System sponsors a noncontributory defined contribution plan covering all bargaining and non-bargaining employees. Employer contributions to the defined contribution plan are based on a formula as defined by the plan document. Costs of the defined contribution plan charged to expense were $13,605 and $12,833 for the years ended December 31, 2017 and 2016, respectively.

(Dollars in Thousands)

9. Pension Plans (continued)

Defined Benefit Plan

The Health System has a frozen noncontributory defined benefit pension plan (the Plan), which covered all employees who met certain criteria. The Health System uses a December 31 measurement date for the Plan. The following tables summarize information about the defined benefit pension plan:

	December 31	
	2017	**2016**
Change in benefit obligation		
Projected benefit obligation at beginning of year	**$ 152,540**	$ 147,252
Service cost	**1,580**	1,440
Interest cost	**6,376**	6,562
Actuarial loss	**11,446**	5,449
Benefits paid	**(6,932)**	(6,841)
Expected administrative expenses	**(1,488)**	(1,322)
Projected benefit obligation, end of year	**$ 163,522**	$ 152,540
Accumulated benefit obligation	**$ 163,522**	$ 152,540
Change in plan assets		
Fair value of plan assets at beginning of year	**$ 137,467**	$ 135,287
Actual return on plan assets, net of expenses	**14,829**	10,343
Benefits paid	**(6,932)**	(6,841)
Administrative expenses	**(1,488)**	(1,322)
Fair value of plan assets at end of year	**$ 143,876**	$ 137,467
Funded status at year-end – recognized on the consolidated balance sheets as accrued retirement benefits	**$ (19,646)**	$ (15,073)
Cumulative amounts recognized in accumulated unrestricted net assets consist of:		
Net unrecognized loss	**$ 39,766**	$ 38,290

(Dollars in Thousands)

9. Pension Plans (continued)

The net unrecognized loss that will be amortized from other changes in unrestricted net assets into net periodic benefit cost over the next fiscal year is $3,560.

	2017	2016
Components of net periodic benefit cost and other amounts recognized in other changes in unrestricted net assets		
Net periodic benefit cost:		
Service cost	**$ 1,580**	$ 1,440
Interest cost	**6,376**	6,563
Expected return on plan assets	**(8,239)**	(8,119)
Recognized actuarial loss	**3,379**	3,350
	$ 3,096	$ 3,234
Other changes in pension benefit obligation recognized in other changes in unrestricted net assets:		
Increase to unrestricted net assets	**$ 1,476**	$ (126)
Assumptions		
Weighted average assumptions used to determine benefit obligations at December 31:		
Discount rate	**3.66%**	4.24%
Rate of compensation increase	**N/A**	N/A
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	**4.24%**	4.52%
Expected long-term return on plan assets	**6.20%**	6.20%
Rate of compensation increase	**N/A**	N/A

To develop the expected long-term rate of return on assets assumption, the Health System considered the historical returns and the future expectations for returns for each asset class, as well as the target allocation of the pension portfolio. This resulted in the selection of the 6.20% long-term rate of return on assets assumption used in 2017 and 2016.

(Dollars in Thousands)

9. Pension Plans (continued)

	Asset Allocation			December 31	
	Minimum	**Target**	**Maximum**	**2017**	**2016**
Plan assets					
Weighted average asset allocations, by asset category:					
Equity securities	30%	20%	10%	**19%**	19%
Debt securities	90	80	70	**81**	81
				100%	100%

The Health System has designed an investment strategy for plan assets such that asset returns are anticipated to track changes in plan liabilities. The objectives of the strategy are to provide an absolute total return on plan assets equal to or greater than 6.2% annually over long-term periods.

The fair values of each major category of plan assets, according to the level within the fair value hierarchy in which the fair value measurements fall in their entirety are as follows:

	Total	**Level 1**	**Level 2**	**Level 3**
December 31, 2017				
Money market funds	**$ 377**	**$ 377**	**$ –**	**$ –**
U.S. Treasury securities	**21,843**	**21,843**	**–**	**–**
Mutual funds	**121,656**	**121,656**	**–**	**–**
	$ 143,876	**$ 143,876**	**$ –**	**$ –**
December 31, 2016				
Money market funds	$ 302	$ 302	$ –	$ –
U.S. Treasury securities	21,274	21,274	–	–
Mutual funds	115,891	115,891	–	–
	$ 137,467	$ 137,467	$ –	$ –

Mutual funds and U.S. Treasury securities are valued at quoted market prices, which represent the net asset value of shares held by the Plan at year-end and are included in Level 1.

(Dollars in Thousands)

9. Pension Plans (continued)

Cash Flows

Contributions

Contributions expected to be made to the Plan during 2018	$	–

Estimated Future Benefit Payments

2018	$	8,014
2019		8,404
2020		8,878
2021		9,162
2022		9,482
2023–2027		49,255

10. Self-Insured Reserves

The Health System self-insures the primary layer of its employee health benefits, professional malpractice, general, and workers' compensation liabilities. Recorded liabilities for the self-insured reserves are as follows:

	December 31			
	2017		**2016**	
Employee health benefits	**$**	**5,592**	$	3,771
Workers' compensation		**5,629**		5,747
Professional and general liability		**63,692**		62,146
		74,913		71,664
Less current portion of self-insured reserves		**19,834**		17,481
	$	**55,079**	$	54,183

The employee health insurance program is administered through a commercial insurance company. The plan provides for covered expenses in any accredited hospital and by any licensed physician. The lifetime plan maximum per person is $1,000.

10. Self-Insured Reserves (continued)

The Health System also provides coverage for all employees for work-related injuries and illnesses. This plan pays for medical expenses and reimburses 70% of lost wages up to the state-defined maximum. Stop-loss coverage is provided at various levels depending upon the circumstances surrounding the injury or illness.

For malpractice claims reported after January 1, 2005, the Health System is self-insured through a trust up to $6,500 per occurrence for hospital incidents and $5,500 per occurrence for physicians and $39,000 in the annual aggregate. Claims in excess of these retained amounts are covered by a commercial claims-made insurance policy.

Claims prior to January 1, 2005, were covered by various programs combining self-insured captive insurance company and commercial claims-made insurance policies. The estimated liability for all unreported claims as of December 31, 2017, and retained uninsured risk for all prior years is included in the self-insured reserves and funded through the self-insured trust (see Note 5).

The estimated losses on self-insured malpractice claims are discounted at a rate of 3.5%. Professional liabilities are discounted based on the expected timing of the actuarially estimated future payments under the program using an interest rate expected to be earned on related invested assets during such future periods. Such estimates are reviewed and updated on an annual basis.

The Health System is also self-insured for general liability coverage, up to $1,000 per occurrence with no annual aggregate, effective January 1, 2010, with a retroactive effective date of August 30, 1994. From January 1, 2003 until December 31, 2009, liability limits were $3,000 per occurrence and from September 1, 1994 until December 31, 2002, limits were $2,000 per occurrence, both with an unlimited annual aggregate.

The estimates for self-insured reserves are based upon complex actuarial calculations which utilize factors such as historical claim experience for the Health System and related industry factors, trending models, estimates for the payment and loss development patterns of future claims, and present value discounting factors. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Revisions to estimated amounts resulting from actual experience differing from projected expectations are recorded in the period the information becomes known or when changes are anticipated.

(Dollars in Thousands)

11. Commitments and Contingencies

Operating Leases

The Health System rents certain equipment and buildings under various operating lease agreements. Rental expense under these lease agreements amounted to $27,315 and $28,352 in 2017 and 2016, respectively.

The future minimum rental payments required under the noncancelable operating leases are as follows:

	Operating Leases
2018	$ 15,069
2019	14,759
2020	13,173
2021	11,253
2022	8,898
Thereafter	6,173

On April 12, 2006, the Health System executed an agreement to lease ground owned by the Health System to the CCIA, upon which a parking facility was constructed. The parking facility was financed and constructed, and is operated by the CCIA. Upon completion of construction in 2007, the Health System leased from the CCIA approximately 57% of the total parking spaces in the facility pursuant to a parking license agreement that was also executed on April 12, 2006. Under the ground lease, the Health System receives base rent of $100 annually over the term of the lease, and may receive additional variable rent based upon the operations of the garage. During the initial term of 15 years, the Health System's parking license fee agreement increases annually 3% during the first 5 years and 1.5% annually thereafter.

Litigation Claims and Settlements

The Health System is involved in litigation and claims which are not considered unusual to the Health System's business. The final outcome of any current or future litigation or governmental or internal investigations cannot be accurately predicted at this time, nor can the Health System predict any resulting penalties, fines, or other sanctions that may be imposed at the discretion of

(Dollars in Thousands)

11. Commitments and Contingencies (continued)

federal or state regulatory authorities. The Health System records accruals for such contingencies to the extent that it concludes it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. While management is not currently aware of issues which have not been accrued at December 31, 2017, it is possible that the outcome of such matters could potentially have a material adverse impact on the Health System's future results of operations, financial position, and cash flows.

Additionally, during the third quarter of 2017, the Health System signed a letter of intent with an unrelated health care provider (the Seller) to acquire a controlling interest in three health care facilities. The Health System paid into escrow an initial deposit of $15,000 in connection with the planned transaction. After a period of due diligence, the Health System determined not to proceed with the transaction. The Health System recorded the escrow deposit within assets limited as to use upon initial payment and as of December 31, 2017. The Health System and the Seller are involved in pending litigation regarding the termination of the letter of intent and escrow funds. The outcome of the litigation is presently unknown.

12. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or have time restrictions as follows:

	December 31	
	2017	**2016**
Purpose:		
Various funds for benefit of the departments, programs, or educational programs of the Health System	**$ 31,465**	$ 27,319
Time restricted	**440**	515
Total temporarily restricted net assets	**$ 31,905**	$ 27,834

The Health System follows the requirements of Uniform Prudent Management of Institutional Funds Act (UPMIFA) as they relate to its endowments. The Health System's endowments consist of numerous individual funds established for a variety of purposes and consist solely of donor-restricted endowment funds. As required by U.S. generally accepted accounting principles, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

(Dollars in Thousands)

12. Temporarily and Permanently Restricted Net Assets (continued)

The Health System has interpreted UPMIFA 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 Health System classifies as permanently restricted net assets the original value of gifts donated to the permanent endowment, the original value of subsequent gifts donated to the permanent endowment, and accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instruments. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is characterized 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 UPMIFA.

Permanently restricted net assets consist of the following permanent endowments:

	December 31	
	2017	**2016**
Women's Board	**$ 1,012**	$ 1,012
Radiology	**501**	501
Lummis Trust	**204**	204
Nursing education	**171**	171
Cleft Palate program	**106**	106
Physical teaching and excellence award	**16**	16
Nespel Estate	**13**	13
Other	**441**	440
Total permanently restricted net assets	**$ 2,464**	$ 2,463

The investment income earned on the above endowments is to be used for the purposes stated above, with the exception of the Nespel Estate and the Lummis Trust, for which the investment income is unrestricted. The principal is to be held in perpetuity.

The Health System has adopted investment policies for its endowment assets that are consistent with the policies and objectives of its overall investments. The assets are invested in a manner that is intended to produce a positive rate of return while assuming a low level of risk. From time to time, the fair value of assets associated with the donor-restricted endowment funds may fall below

(Dollars in Thousands)

12. Temporarily and Permanently Restricted Net Assets (continued)

the level that the donor requires the Health System to maintain in perpetual duration. Deficiencies of this nature are reported in unrestricted net assets in accordance with U.S. generally accepted accounting principles.

Temporarily restricted net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events specified by donors.

	Year Ended December 31	
	2017	**2016**
Purpose:		
Various funds for benefit of the departments, programs, or educational programs of the Health System	**$ 2,792**	$ 6,571
Total temporarily restricted net assets	**$ 2,792**	$ 6,571

13. Other Revenue

Other revenue consists of the following:

	Year Ended December 31	
	2017	**2016**
Grant revenue	**$ 16,537**	$ 20,250
Medical school support	**3,388**	16,297
Grow NJ tax credits	**4,236**	4,111
Food services	**5,869**	3,644
Centers for population health	**1,721**	1,461
Retail pharmacy cost sharing	**7,619**	9,083
Physician services	**16,355**	15,183
Emergency/air transport	**7,538**	5,073
Net assets released from restrictions for operating purposes	**2,792**	6,571
Other	**10,775**	11,782
	$ 76,830	$ 93,455

(Dollars in Thousands)

13. Other Revenue (continued)

In December 2015, the Health System entered into a transaction as part of the state of New Jersey's Grow NJ tax credit program, under which the Health System will receive state tax credits over a ten-year period which are available for sale by the Health System, subject to annual re-certifications. The Health System sold tax credits totaling $4,236 and $4,111 in the years ended December 2017 and 2016, respectively, which was recorded in other revenue on the consolidated statement of operations and change in net assets.

14. Functional Expenses

The Health System provides general health care services to residents within its service area. Expenses related to providing these services included on the consolidated statements of operations and changes in net assets are as follows:

	Year Ended December 31	
	2017	**2016**
Health care services	**$ 605,323**	$ 570,773
General and administrative	**243,527**	229,436
Physician services	**349,021**	317,939
	$ 1,197,871	$ 1,118,148

15. Rowan University Affiliation

In 2010, the Health System executed an affiliation agreement with Rowan University. This affiliation agreement governs the roles and duties of each party with respect to The Cooper Medical School of Rowan University. The Health System receives an annual state appropriation for affiliate hospital support. The Health System received $4,522 and $14,938 of state appropriation during the years ended December 31, 2017 and 2016, respectively.

16. Subsequent Events

The Health System has evaluated subsequent events through April 25, 2018, the date when the accompanying consolidated financial statements were issued. No subsequent events have occurred that require disclosure in or adjustment to the consolidated financial statements.

Supplementary Information

The Cooper Health System

Consolidating Balance Sheet
(In Thousands)

December 31, 2017

	The Cooper Health System Obligated Group									
	The Cooper Health System	The Cooper Cancer Center	Eliminating Entries	The Cooper Health System Obligated Group	The Cooper Foundation	C&H Collection Services	Cooper HealthCare Properties, Inc.	Cooper Medical Services, Inc.	Eliminating Entries	The Cooper Health System Consolidated
Assets										
Current assets:										
Cash and cash equivalents	$ 212,618	$ 247	$ –	$ 212,865	$ 4,666	$ –	$ –	$ 12,319	$ –	$ 229,850
Current portion of assets limited as to use	36,695	–	–	36,695	–	–	–	–	–	36,695
Patient accounts receivable, net of allowance for doubtful accounts	158,146	–	–	158,146	–	–	–	–	–	158,146
Prepaid expenses and other assets	46,301	2,337	(2,337)	46,301	17	443	–	–	–	46,761
Due from affiliates	1,405	8,335	(8,335)	1,405	–	660	1,268	–	(3,333)	–
Total current assets	455,165	10,919	(10,672)	455,412	4,683	1,103	1,268	12,319	(3,333)	471,452
Assets limited as to use:										
Internally designated by Board of Trustees	233,675	–	–	233,675	–	–	–	–	–	233,675
Externally designated for donor purposes	–	–	–	–	47,403	–	–	–	–	47,403
Externally designated under debt agreement, net of current portion	3,761	–	–	3,761	–	–	–	–	–	3,761
Designated under self-insurance programs, net of current portion	29,243	–	–	29,243	–	–	–	–	–	29,243
Assets limited as to use, net of current portion	266,679	–	–	266,679	47,403	–	–	–	–	314,082
Property, plant, and equipment, net	447,771	41,355	–	489,126	–	–	953	13,639	–	503,718
Other assets, net	2,546	721	–	3,267	487	–	1,036	–	–	4,790
Notes receivable	15,781	–	–	15,781	–	–	–	–	–	15,781
Due from affiliates	–	–	–	–	–	–	–	31,422	(31,422)	–
Total assets	$ 1,187,942	$ 52,995	$ (10,672)	$ 1,230,265	$ 52,573	$ 1,103	$ 3,257	$ 57,380	$ (34,755)	$ 1,309,823
Liabilities and net assets										
Current liabilities:										
Accounts payable	$ 30,117	$ –	$ –	$ 30,117	$ –	$ –	$ –	$ –	$ –	$ 30,117
Accrued expenses	117,362	–	–	117,362	–	393	6	573	–	118,334
Current portion of estimated settlement due to third-party payors	484	–	–	484	–	–	–	–	–	484
Current portion of self-insured reserves	19,834	–	–	19,834	–	–	–	–	–	19,834
Current portion of long-term debt	6,204	–	–	6,204	–	–	49	1,248	–	7,501
Due to affiliates	8,335	–	(8,335)	–	3,160	–	–	173	(3,333)	–
Total current liabilities	182,336	–	(8,335)	174,001	3,160	393	55	1,994	(3,333)	176,270
Estimated settlements due to third-party payors, net of current portion	8,012	–	–	8,012	–	–	–	–	–	8,012
Accrued retirement benefits	19,646	–	–	19,646	–	–	–	–	–	19,646
Self-insured reserves, net of current portion	55,079	–	–	55,079	–	–	–	–	–	55,079
Long-term debt, net of current portion	250,856	–	–	250,856	–	–	272	43,205	–	294,333
Deferred revenue and other liabilities	16,496	–	(2,337)	14,159	–	–	–	2,376	–	16,535
Due to affiliates	31,422	–	–	31,422	–	–	–	–	(31,422)	–
Notes payable	–	22,296	–	22,296	–	–	–	–	–	22,296
Total liabilities	563,847	22,296	(10,672)	575,471	3,160	393	327	47,575	(34,755)	592,171
Net assets:										
Unrestricted	623,656	30,699	–	654,355	15,483	710	2,930	9,805	–	683,283
Temporarily restricted	–	–	–		31,905	–	–	–	–	31,905
Permanently restricted	439	–	–	439	2,025	–	–	–	–	2,464
Total net assets	624,095	30,699	–	654,794	49,413	710	2,930	9,805	–	717,652
Total liabilities and net assets	$ 1,187,942	$ 52,995	$ (10,672)	$ 1,230,265	$ 52,573	$ 1,103	$ 3,257	$ 57,380	$ (34,755)	$ 1,309,823

The Cooper Health System

Consolidating Statement of Operations and Changes in Net Assets
(In Thousands)

Year Ended December 31, 2017

	The Cooper Health System Obligated Group									
	The Cooper Health System	The Cooper Cancer Center	Eliminating Entries	The Cooper Health System Obligated Group	The Cooper Foundation	C&H Collection Services	Cooper HealthCare Properties, Inc.	Cooper Medical Services, Inc.	Eliminating Entries	The Cooper Health System Consolidated
Unrestricted net assets										
Revenue:										
Net patient service revenue	$ 1,205,304	$ –	$ –	$ 1,205,304	$ –	$ –	$ –	$ –	$ –	$ 1,205,304
Provision for bad debts	(84,695)	–	–	(84,695)	–	–	–	–	–	(84,695)
Net patient service revenue less provision for bad debts	1,120,609	–	–	1,120,609	–	–	–	–	–	1,120,609
Other revenue	75,035	1,380	(1,380)	75,035	3,206	1,312	830	7,493	(11,046)	76,830
Total revenue	1,195,644	1,380	(1,380)	1,195,644	3,206	1,312	830	7,493	(11,046)	1,197,439
Expenses:										
Salaries, wages, and fringe benefits	713,947	–	–	713,947	–	653	–	–	–	714,600
Supplies and other	404,678	130	(1,380)	403,428	3,878	515	526	5,379	(11,046)	402,680
Malpractice	17,892	–	–	17,892	–	–	–	–	–	17,892
Depreciation and amortization	44,202	3,162	–	47,364	–	–	43	1,154	–	48,561
Interest	12,455	269	–	12,724	–	–	20	1,394	–	14,138
Total expenses	1,193,174	3,561	(1,380)	1,195,355	3,878	1,168	589	7,927	(11,046)	1,197,871
Operating income (loss)	2,470	(2,181)	–	289	(672)	144	241	(434)	–	(432)
Nonoperating gains and losses:										
Transaction-related costs	(2,608)	–	–	(2,608)	–	–	–	–	–	(2,608)
Investment return	12,872	–	–	12,872	947	–	–	–	–	13,819
Net change unrealized gains and losses on trading securities	3,550	–	–	3,550	3261	–	–	–	–	6,811
Gain on fixed asset disposal	–	–	–	–	–	–	–	890	–	890
Change in value of equity method investments	(865)	–	–	(865)	–	–	–	1,154	–	289
Change in fair value of interest rate swap agreements	445	–	–	445	–	–	–	–	–	445
Excess (deficiency) of revenue over expenses	15,864	(2,181)	–	13,683	3,536	144	241	1,610	–	19,214
Other changes in unrestricted net assets:										
Change in pension benefit obligation	(1,476)	–	–	(1,476)	–	–	–	–	–	(1,476)
Contributions for capital acquisitions	10,144	–	–	10,144	–	–	–	–	–	10,144
Net change in unrealized gains and losses on other-than-trading securities	1,526	–	–	1,526	–	–	–	–	–	1,526
Increase (decrease) in unrestricted net assets	26,058	(2,181)	–	23,877	3,536	144	241	1,610	–	29,408
Temporarily restricted net assets										
Contributions, gifts, and special events, net of fundraising expenses	–	–	–	–	5,784	–	–	–	–	5,784
Income from investments	–	–	–	–	515	–	–	–	–	515
Net realized and unrealized gains on investments	–	–	–	–	564	–	–	–	–	564
Net assets released from restrictions for operating purposes	–	–	–	–	(2,792)	–	–	–	–	(2,792)
Increase in temporarily restricted net assets	–	–	–	–	4,071	–	–	–	–	4,071
Permanently restricted net assets										
Net change in unrealized gain and losses on investments	–	–	–	–	1	–	–	–	–	1
Increase in permanently restricted net assets	–	–	–	–	1	–	–	–	–	1
Increase (decrease) in net assets	26,058	(2,181)	–	23,877	7,608	144	241	1,610	–	33,480
Net assets, beginning of year	598,037	32,880	–	630,917	41,805	566	2,689	8,195	–	684,172
Net assets, end of year	$ 624,095	$ 30,699	$ –	$ 654,794	$ 49,413	$ 710	$ 2,930	$ 9,805	$ –	$ 717,652

EY | Assurance | Tax | Transactions | Advisory

About EY
EY is a global leader in assurance, tax, transaction and advisory services. The insights and quality services we deliver help build trust and confidence in the capital markets and in economies the world over. We develop outstanding leaders who team to deliver on our promises to all of our stakeholders. In so doing, we play a critical role in building a better working world for our people, for our clients and for our communities.

EY refers to the global organization, and may refer to one or more, of the member firms of Ernst & Young Global Limited, each of which is a separate legal entity. Ernst & Young Global Limited, a UK company limited by guarantee, does not provide services to clients. For more information about our organization, please visit ey.com.

ey.com