Consolidated Financial Statements and Supplementary Information

The Cooper Health System
Years Ended December 31, 2018 and 2017
With Report of Independent Auditors

Ernst & Young LLP

The Cooper Health System

Consolidated Financial Statements
and Supplementary Information

Years Ended December 31, 2018 and 2017

Contents

Building a better working world

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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, 2018 and 2017, 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, 2018 and 2017, 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.

Adoption of ASU No. 2014-09, *Revenue from Contracts with Customers*, and ASU No. 2016-14, *Not-for-Profit Entities: Presentation of Financial Statements of Not-for-Profit Entities*

As discussed in Note 2 to the consolidated financial statements, The Cooper Health System changed its method of revenue recognition as a result of the adoption of the amendments to the Financial Accounting Standard Board (FASB) Accounting Standards Codification (ASC) resulting from Accounting Standards Update No. (ASU) 2014-09, *Revenue from Contracts with Customers*, effective January 1, 2018, and adopted the amendments to the FASB ASC resulting from ASU 2016-14, *Not-for-Profit Entities: Presentation of Financial Statements of Not-for-Profit Entities*, effective December 31, 2018. Our opinion is not modified with respect to these matters.

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, 2018, 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 29, 2019

The Cooper Health System

Consolidated Balance Sheets
(In Thousands)

	December 31 2018	2017
Assets		
Current assets:		
Cash and cash equivalents	**$ 285,926**	$ 229,850
Current portion of assets limited as to use	**28,092**	21,695
Patient accounts receivable, net of allowance for doubtful accounts of $2,543 and $47,305 in 2018 and 2017, respectively	**138,860**	158,146
Prepaid expenses and other current assets	**51,518**	46,761
Total current assets	**504,396**	456,452
Assets limited as to use:		
Internally designated by Board of Trustees	**231,473**	233,675
Externally designated for donor purposes	**45,904**	47,403
Externally designated under debt agreements, net of current portion	**3,807**	3,761
Externally designated – escrow agreement	**15,006**	15,000
Designated under self-insurance programs, net of current portion	**17,414**	29,243
Assets limited as to use, net of current portion	**313,604**	329,082
Property, plant, and equipment, net	**534,356**	503,718
Other assets, net	**7,309**	4,790
Notes receivable	**15,781**	15,781
Total assets	**$ 1,375,446**	$ 1,309,823

	December 31	
	2018	**2017**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 27,305**	$ 30,117
Accrued expenses	**133,972**	118,334
Current portion of estimated settlements due to third-party payors	**354**	484
Current portion of self-insured reserves	**25,421**	19,834
Current portion of long-term debt	**7,883**	7,501
Total current liabilities	**194,935**	176,270
Estimated settlements due to third-party payors, net of current portion	**5,548**	8,012
Accrued retirement benefits	**21,172**	19,646
Self-insured reserves, net of current portion	**53,118**	55,079
Long-term debt, net of current portion	**291,646**	294,333
Deferred revenue and other liabilities	**14,518**	16,535
Notes payable	**22,296**	22,296
Total liabilities	**603,233**	592,171
Net assets:		
Without donor restrictions	**731,360**	683,283
With donor restrictions	**40,853**	34,369
Total net assets	**772,213**	717,652
Total liabilities and net assets	**$ 1,375,446**	$ 1,309,823

See accompanying notes.

The Cooper Health System

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

	Year Ended December 31	
	2018	**2017**
Net assets without donor restrictions		
Revenue:		
Net patient service revenue	**$ 1,209,359**	$ 1,205,304
Provision for bad debts	**–**	(84,695)
Net patient service revenue less provision for bad debts	**1,209,359**	1,120,609
Other revenue	**83,347**	76,830
Total revenue	**1,292,706**	1,197,439
Expenses:		
Salaries, wages, and fringe benefits	**751,965**	714,600
Supplies and other	**422,136**	402,680
Malpractice	**24,888**	17,892
Depreciation and amortization	**51,526**	48,561
Interest	**14,208**	14,138
Total expenses	**1,264,723**	1,197,871
Operating income (loss)	**27,983**	(432)
Nonoperating gains and (losses):		
Transaction-related costs	**(350)**	(2,608)
Investment return	**10,287**	13,819
Net change in unrealized gains and (losses) on trading securities	**(11,749)**	6,811
Gain on fixed asset disposal	**–**	890
Change in value of equity method investments	**(390)**	289
Change in fair value of interest rate swap agreements	**973**	445
Excess of revenue over expenses	**26,754**	19,214
Other changes in net assets without donor restrictions:		
Change in pension benefit obligation	**1,448**	(1,476)
Contributions received and expended for capital acquisitions	**22,087**	10,144
Net change in unrealized gains and (losses) on other-than-trading securities	**(2,212)**	1,526
Increase in net assets without donor restrictions	**48,077**	29,408

The Cooper Health System

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

	Year Ended December 31	
	2018	**2017**
Net assets with donor restrictions		
Contributions, gifts, and special events, net of fundraising expense	**$ 5,561**	$ 5,784
Income from investments	**507**	515
Net realized and unrealized gains on investments	**837**	565
Net assets released from restrictions for operating purposes	**(421)**	(2,792)
Increase in net assets with donor restrictions	**6,484**	4,072
Increase in net assets	**54,561**	33,480
Net assets, at beginning of year	**717,652**	684,172
Net assets, at end of year	**$ 772,213**	$ 717,652

See accompanying notes.

The Cooper Health System

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended December 31	
	2018	**2017**
Operating activities		
Increase in net assets	**$ 54,561**	$ 33,480
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Change in pension benefit obligation	**(1,448)**	1,476
Change in fair value of interest rate swap agreements	**(973)**	(445)
Depreciation and amortization	**51,526**	48,561
Gain on property, plant, and equipment disposal	**–**	(890)
Provision for bad debts	**–**	84,695
Net realized and unrealized gains and losses on investments	**11,186**	(14,498)
Change in value of equity method investments	**390**	(289)
Contributions for capital acquisitions	**(22,087)**	(10,144)
Changes in certain assets and liabilities:		
Patient accounts receivable	**19,286**	(69,357)
Prepaid expenses and other assets	**(3,748)**	5,535
Accounts payable and accrued expenses	**12,826**	8,515
Self-insured reserves and accrued retirement benefits	**6,600**	6,346
Estimated settlements with third-party payors	**(2,594)**	(510)
Deferred revenue and other liabilities	**(1,044)**	4,243
Net cash provided by operating activities	**124,481**	96,718
Investing activities		
Purchases of assets limited as to use	**(2,105)**	(18,221)
Acquisition of equity method investment	**(3,918)**	–
Capital expenditures, net	**(83,418)**	(47,507)
Net cash used in investing activities	**(89,441)**	(65,728)
Financing activities		
Repayments of long-term debt	**(7,486)**	(9,598)
Proceeds from long-term debt	**6,435**	–
Contributions for capital acquisitions	**22,087**	10,144
Net cash provided by financing activities	**21,036**	546
Net increase in cash and cash equivalents	**56,076**	31,536
Cash and cash equivalents at beginning of year	**229,850**	198,314
Cash and cash equivalents at end of year	**$ 285,926**	$ 229,850
Supplemental disclosure of cash flow information		
Cash paid for interest	**$ 14,954**	$ 15,393

See accompanying notes.

The Cooper Health System

Notes to Consolidated Financial Statements
(Dollars in Thousands)

December 31, 2018

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 and related physician practices.

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 Foundation's 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 2018 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.

Advertising Costs

The Health System expenses advertising cost as incurred. In 2018 and 2017, the Health System incurred advertising expenses of $7,537 and $5,493, respectively, which are included in supplies and other expense on the consolidated statements of operations and changes in net assets.

2. Summary of Significant Accounting Policies (continued)

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.

Prior to January 1, 2018, the Health System provided 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. As described below, as a result of the adoption of Accounting Standards Update No. (ASU) 2014-09, beginning on January 1, 2018, the majority of the provision for bad debts as previously recorded is considered an implicit price concession and therefore is shown as a direct reduction to net patient service revenue as opposed to a provision for bad debt. As such, beginning on January 1, 2018, additions to the allowance for uncollectibles result only from a delinquency of patient accounts that were considered collectible at the time patient care was provided.

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.

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) or held by trustees under debt agreements (including debt service interest, principal, and reserve funds and funds for future capital expenditures), assets for self-insurance programs (includes trusts for workers' compensation and for medical professional and general liability), and funds related to 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.

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.

2. Summary of Significant Accounting Policies (continued)

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 interests in funds of funds, structured as limited partnerships. 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. Investment return is reported net of external and direct internal investment expenses, such as trustee fees and investment fund manager fees. 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 net assets without donor restrictions.

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. 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

2. Summary of Significant Accounting Policies (continued)

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.

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, 2018 or 2017.

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 the risks.

2. Summary of Significant Accounting Policies (continued)

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 net assets without donor restrictions 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 income (loss).

Classification of Net Assets

The Health System separately accounts for and reports net assets without donor restrictions and net assets with donor restrictions. Net assets without donor restrictions are not externally restricted for identified purposes by donors or grantors. Net assets without donor restrictions 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.

Net assets with donor restrictions are those whose use by the Health System has been limited by donors to a specific time period or purpose, or have been restricted by donors as permanent endowments to be maintained in perpetuity. When the donors' intentions are met or a time restriction expires for net assets limited by donors to a specific time period or purpose, the net assets are reclassified to net assets without donor restrictions and reported on the consolidated statements of operations and changes in net assets as net assets released from restrictions.

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; however, CHCS's provision for income taxes is not material to the Health System's consolidated results of operations.

2. Summary of Significant Accounting Policies (continued)

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. For tax-exempt entities, TCJA requires organizations to categorize certain fringe benefit expenses as a source of unrelated business income subject to tax, pay an excise tax on compensation above certain thresholds, and record income or losses for tax determination purposes from unrelated business activities on an activity-by-activity basis, among other provisions. Regulations necessary to implement certain aspects of TCJA are expected to be promulgated by the Internal Revenue Service (IRS) in 2019. As of and for the year ended December 31, 2018, the Health System has made reasonable estimates of the provision for income taxes, the compensation excise tax, and the effects, if any, on existing deferred tax balances based on accounting guidance included in Accounting Standards Codification (ASC) 740, *Income Taxes*. The Health System will continue to refine its calculations in future periods as additional regulations and guidance are issued by the IRS. The tax provision was not material for the year ended December 31, 2018.

Reclassifications

Certain reclassifications have been made to the 2017 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

Adopted Changes

In May 2014, the Financial Accounting Standards Board (FASB) issued 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 prior revenue recognition requirements in 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 became effective for the Health System for annual reporting periods beginning after December 15, 2017. The Health System adopted ASU 2014-09 effective January 1, 2018, for its consolidated financial statements. The Health System adopted ASU 2014-09 following the modified retrospective method. As a result of implementing ASU 2014-09, certain patient activity where collection is

2. Summary of Significant Accounting Policies (continued)

uncertain (representing approximately $58,800 for the year ended December 31, 2018) previously reported through December 31, 2017, as net patient service revenue and provision for bad debts in the Health System's consolidated statements of operations and changes in net assets no longer meets the criteria for revenue recognition and, accordingly, the provision for bad debts after the adoption date is significantly reduced with a corresponding reduction to net patient service revenue. Such patient activity is now classified as an implicit price concession (see Note 3). Additionally, the provision for bad debts, when applicable, will be presented as an expense item rather than a reduction to net patient service revenue. Other aspects of the System's implementation of ASU 2014-09 impacting net patient service revenue, which include judgments regarding collection analyses and estimates of variable consideration and the addition of certain qualitative and quantitative disclosures are reflected in Note 3. The adoption of ASU 2014-09 in relation to other revenue activity had no material impact to the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Not-for-Profit Entities: 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 are required to classify net assets as net assets with donor restrictions or without donor restrictions. The guidance also modified required disclosures and reporting related to net assets, investment expenses, and information regarding liquidity. NFPs are also required to report all expenses by both functional and natural classification in one location. The provisions of ASU 2016-14 became effective for the Health System for annual periods beginning after December 15, 2017. The Health System adopted ASU 2016-14 effective for its consolidated financial statements as of and for the year ended December 31, 2018.

Pending Changes

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 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 is in the process of evaluating the impact of ASU 2016-02 on its consolidated financial statements. Assets and liabilities will increase to reflect the Health System's right to use certain assets and the corresponding liabilities associated with operating leases, with no significant impact to net assets or the performance indicator.

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 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

2. Summary of Significant Accounting Policies (continued)

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 ($1,460 and $1,580 for 2018 and 2017, 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 $1,514 and $1,516 for 2018 and 2017, respectively) as a separate line 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.

In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958); Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. ASU 2018-08 clarifies existing guidance in order to address diversity in practice in classifying grants (including governmental grants) and contracts received by not-for-profit entities, and requires entities to evaluate whether the resource provider receives commensurate value. In addition, the standard clarifies the guidance on how entities determine when a contribution is conditional, including whether the agreement includes a barrier (or barriers) that must be overcome for the recipient to be entitled to the transferred assets and a right of return of the transferred assets (or a right of release of the promisor's obligation to transfer the assets). The standard should be applied

2. Summary of Significant Accounting Policies (continued)

on a modified prospective basis to agreements that are not completed as of the effective date and to agreements entered into after the effective date. Retrospective application is permitted. ASU 2018-08 applies to all entities that make or receive contributions and is effective for the Health System for fiscal years beginning after June 15, 2018, including interim periods within those years. Early adoption is permitted. The Health System is in the process of evaluating the impact of ASU 2018-08 on its consolidated financial statements.

In August 2018, the FASB issued ASU 2018-15, *Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract*. The standard aligns the requirement for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal use software license). The accounting for the service element of a hosting arrangement that is a service contract is not affected by this standard. The standard requires the customer in a hosting arrangement that is a service contract to follow the guidance in ASC Subtopic 350-40 to determine which implementation costs to capitalize as an asset related to the service contract and which costs to expense by determining which project stage an implementation activity relates to and the nature of the costs. The standard also requires the customer to expense the capitalized implementation costs of a hosting arrangement that is a service contract over the term of the hosting arrangement. ASU 2018-15 is effective for the Health System for fiscal years beginning after December 15, 2020, and interim periods within fiscal years beginning after December 15, 2021. Early adoption is permitted, including adoption in any interim period. Either retrospective or prospective adoption is permitted. The Health System is in the process of evaluating the impact of ASU 2018-15 on its consolidated financial statements.

The FASB has amended certain guidance related to various disclosures in ASU 2018-09, *Codification Improvements*, ASU 2018-13, *Technical Corrections and Improvements to Financial Instruments – Overall (Subtopic 825-10) – Recognition and Measurement of Financial Assets and Financial Liabilities*, and ASU 2018-14, *Compensation – Retirement Benefits – Defined Benefit Plans – General (Subtopic 715-20) – Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans*. Among various provisions, ASU 2018-09 may result in additional assets included in an entity's fair value disclosure table if, among other criteria, net asset value has public visibility. ASU 2018-13 includes several disclosure changes involving transfers between the fair value levels and other updates related to fair value Level 3 investments. ASU

2. Summary of Significant Accounting Policies (continued)

2018-13 also requires entities that use the practical expedient to measure the fair value of certain investments at their net asset values to disclose (1) the timing of liquidation of an investee's assets and (2) the date when redemption restrictions will lapse, but only if the investee has communicated this information to the entity or announced it publicly. The guidance in ASU 2018-14 requires all sponsors of defined benefit plans to provide certain new disclosures: the weighted-average interest crediting rate for cash balance plans and other plans with promised interest crediting rates and an explanation of the reasons for significant gains and losses related to changes in the benefit obligation for the period. Among other changes, ASU 2018-14 eliminates the required disclosure for all sponsors of defined benefit plans to disclose the amounts in accumulated other comprehensive income expected to be recognized as components of net periodic benefit cost over the next fiscal year. The updates noted above have effective dates as follows with early adoption permitted: ASU 2018-09: fiscal years beginning after December 15, 2018; ASU 2018-13: fiscal years beginning after December 15, 2019; and ASU 2018-14: fiscal years ending after December 15, 2021. The Health System has not completed the process of evaluating the impact of these ASUs on its consolidated financial statements.

3. Net Patient Service Revenue

Accounts Receivable and Net Patient Service Revenue

For Periods Commencing January 1, 2018

Effective January 1, 2018 upon the adoption of ASU 2014-09, net patient service revenue is reported at the amount that reflects the consideration to which the Health System expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration (reductions to revenue) for retroactive revenue adjustments due to settlement of ongoing and future audits, reviews, and investigations.

The Health System uses a portfolio approach to account for categories of patient contracts as a collective group rather than recognizing revenue on an individual contract basis. The portfolios consist of major payor classes for inpatient revenue and outpatient revenue as well as high-balanced accounts regardless of payor class. Based on historical collection trends and other analyses, the Health System believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

3. Net Patient Service Revenue (continued)

The Health System's initial estimate of the transaction price for services provided to patients subject to revenue recognition is determined by reducing the total standard charges related to the patient services provided by various elements of variable consideration, including contractual adjustments, discounts, implicit price concessions, and other reductions to the Health System's standard charges. The Health System determines the transaction price associated with services provided to patients who have third-party payor coverage on the basis of contractual or formula-driven rates for the services rendered (see description of third-party payor payment programs below). The estimates for contractual allowances and discounts are based on contractual agreements, the Health System's discount policies and historical experience. For uninsured and underinsured patients who do not qualify for charity care, the Health System determines the transaction price associated with services on the basis of charges reduced by implicit price concessions. Implicit price concessions included in the estimate of the transaction price are based on the Health System's historical collection experience for applicable patient portfolios. Under the Health System's charity care policy, a patient who has no insurance or is underinsured and is ineligible for any government assistance program has his or her bill reduced to (1) the lesser of charges or the Medicaid diagnostic-related group for inpatient and (2) a discount from Medicaid fee-for-service rates for outpatient. Patients who meet the Health System's criteria for charity care are provided care without charge; such amounts are not reported as revenue.

Generally, the Health System bills patients and third-party payors several days after the services are performed and/or the patient is discharged. Net patient service revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by the Health System. Net patient service revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total charges. The Health System believes that this method provides a reasonable depiction of the transfer of services over the term of the performance obligation based on the services needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services or patients receiving services in the Health System's outpatient and ambulatory care centers. The Health System measures the performance obligation from admission into the hospital or the commencement of an outpatient service to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or the completion of the outpatient visit.

(Dollars in Thousands)

3. Net Patient Service Revenue (continued)

As substantially all of its performance obligations relate to contracts with a duration of less than one year, the Health System has elected to apply the optional exemption provided in ASU 2014-09 and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period for patients who remain admitted at that time (in-house patients). The performance obligations for in-house patients are generally completed when the patients are discharged, which for the majority of the Health System's in-house patients occurs within days or weeks after the end of the reporting period.

Subsequent changes to the estimate of the transaction price (determined on a portfolio basis when applicable) are generally recorded as adjustments to patient service revenue in the period of the change. For the year ended December 31, 2018, changes in the Health System's estimates of implicit price concessions, discounts, contractual adjustments, or other reductions to expected payments for performance obligations satisfied in prior periods were not significant. Portfolio collection estimates are updated quarterly based on collection trends. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (determined on a portfolio basis when applicable) are recorded as bad debt expense. Bad debt expense for the year ended December 31, 2018, was not significant.

The Health System has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors: payors and lines of business. Tables providing details of these factors are presented below.

Net patient service revenue for the year ended December 31, 2018, recognized in the period from these major payor sources, based on primary insurance designation, is as follows:

Medicare	$ 457,413
Medicaid	268,382
Commercial carriers and health maintenance organizations	435,866
State subsidies (See Note 4)	20,533
Self-pay	27,165
	$ 1,209,359

(Dollars in Thousands)

3. Net Patient Service Revenue (continued)

Deductibles, copayments, and coinsurance under third-party payment programs within the third-party payors amounts above are the patient's responsibility and the Health System considered these amounts in its determination of collection estimates.

Net patient service revenue for the year ended December 31, 2018, by line of business is as follows:

Hospital	$ 928,587
Physician services	280,772
	$ 1,209,359

The Health System has elected the practical expedient allowed under ASU 2014-09 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Health System's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Health System does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

At December 31, 2018, accounts receivable is comprised of the following components:

Patient receivables	$ 127,222
Contract assets	11,638
	$ 138,860

Contract assets are related to in-house patients who were provided services during the reporting period but were not discharged as of the reporting date and for which the Health System may not have the right to bill.

Settlements with third-party payors (see description of third-party payor payment programs below) for cost report filings and retroactive adjustments due to ongoing and future audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Health System's historical settlement activity (for example, cost report final settlements or repayments

(Dollars in Thousands)

3. Net Patient Service Revenue (continued)

related to recovery audits), including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Such estimates are determined through either a probability-weighted estimate or an estimate of the most likely amount, depending on the circumstances related to a given estimated settlement item. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations.

During 2018, the Health System revised estimates made in prior years to reflect the passage of time and the availability of more recent information, such as accounts receivable payor collection trends and cost report settlement activity, associated with the related revenue estimates. For the year ended December 31, 2018, the net effect of the Health System's revisions to prior year estimates resulted in net patient service revenue decreasing by approximately $4,000.

For Periods Through December 31, 2017

Prior to the adoption of ASU 2014-09, the Health System recognized patient service revenue at the estimated net realizable amounts associated with services provided to patients who have third-party payor coverage on the basis of contractual or formula-driven rates for the services rendered (see description of third-party payor payment programs below) and included estimated retroactive revenue adjustments due to ongoing and future audits, reviews, and investigations. For uninsured and underinsured patients who did not qualify for charity care, the Health System recognized revenue on the basis of charges. Under the charity care policy, a patient who had no insurance or was underinsured and was ineligible for any government assistance program had his or her bill reduced to (1) the lesser of charges or the Medicaid diagnostic-related group for inpatient and (2) a discount from Medicaid fee-for-service rates for outpatient.

Patient service revenue for the year ended December 31, 2017, net of contractual allowances and discounts (but before the provision for bad debts), recognized from these major payor sources based on primary insurance designation, and is as follows:

Third-party payors	$ 1,190,143
Self-pay	15,161
	$ 1,205,304

3. Net Patient Service Revenue (continued)

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

Accounts receivable are reduced by an allowance for doubtful accounts. The Health System's allowance for doubtful accounts totaled $47,305 at December 31, 2017. In evaluating the collectability 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.

3. Net Patient Service Revenue (continued)

The allowance for doubtful accounts for self-pay patients was approximately 98% of self-pay accounts receivable as of December 31, 2017. The Health system did not experience significant changes in write-off trends and did not change its charity care policy in 2017.

Revenue from the Medicare and Medicaid programs accounted for approximately 53% of the Health system's net patient service revenue for the year ended December 31, 2017.

During 2017, the Health system revised estimates made in prior years to reflect the passage of time and the availability of more recent information, such as settlement activity, associated with the related payment items. For the year ended December 31, 2017, the net effect of the Health system's revisions to prior year settlement estimates resulted in net patient service revenue increasing by approximately $2,172.

Third-Party Payment Programs

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 2016 have been settled by Medicare. The cost reports for fiscal years 2010 and 2017 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.

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 or will be 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.

(Dollars in Thousands)

3. Net Patient Service Revenue (continued)

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

	December 31	
	2018	**2017**
Commercial	**23%**	18%
Health maintenance organizations	**38**	42
Medicare	**18**	22
Blue Cross	**15**	11
Self-pay (including accounts which may ultimately be charity care)	**3**	4
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 $27,671 and $26,905 for the years ended December 31, 2018 and 2017, 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. For the year ended December 31, 2018, and for services provided subsequent to the adoption of ASU 2014-09 on January 1, 2018, for patients who were determined by the Health System to have the ability to pay but did not, the expected uncollected amounts are classified as

(Dollars in Thousands)

4. Charity Care and State Subsidies (continued)

an implicit price concession which reduces net patient service revenue ($58,800 in 2018). For patient services provided prior to December 31, 2017, prior to the adoption of ASU 2014-09, for patients who were determined by the Health System to have the ability to pay but did not, the uncollected amounts were classified as provision for bad debt ($84,695 in 2017).

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

	Year Ended December 31	
	2018	**2017**
Charity Care Subsidy Fund	**$ 13,546**	$ 16,759
Delivery System Reform Incentive Payment Pool	**6,987**	7,180
	$ 20,533	$ 23,939

(Dollars in Thousands)

5. Assets Limited as to Use, Investment Income, and Liquidity

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

	December 31	
	2018	**2017**
Internally designated by Board of Trustees:		
Cash and cash equivalents	**$ 5,522**	$ 9,111
Equity securities:		
U.S. companies	**49,966**	56,991
International companies	**1,495**	2,219
U.S. Treasury securities	**13,412**	17,965
Governmental asset-backed securities	**8,900**	9,024
Mutual funds	**5,396**	6,292
Alternative investments, at equity method value	**30,273**	10,665
Corporate bonds	**116,509**	121,408
	$ 231,473	$ 233,675
Externally designated for donor purposes:		
Cash and cash equivalents	**$ 907**	$ 585
Equity securities:		
U.S. companies	**25,542**	27,692
International companies	**–**	5
U.S. Treasury securities	**11,345**	7,909
Governmental asset-backed securities	**–**	503
Corporate bonds	**8,110**	10,709
	$ 45,904	$ 47,403
Externally designated – under debt agreements:		
Cash and cash equivalents	**$ 12,424**	$ 12,194
Less current portion	**8,617**	8,433
	$ 3,807	$ 3,761

(Dollars in Thousands)

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

	December 31	
	2018	**2017**
Assets held under debt agreements are maintained for the following purposes:		
Debt service interest funds	**$ 3,962**	$ 4,049
Debt service principal funds	**4,655**	4,384
Debt service reserve funds	**261**	257
Capital addition funds	**3,546**	3,504
	$ 12,424	$ 12,194
Designated – under self-insurance programs:		
Cash and cash equivalents	**$ 1,763**	$ 3,684
U.S. Treasury securities	**5,091**	6,536
Governmental asset-backed securities	**8,117**	3,476
Mutual funds	**7,164**	10,640
Corporate bonds	**14,754**	18,169
	36,889	42,505
Less current portion	**19,475**	13,262
	$ 17,414	$ 29,243
Externally designated – escrow agreement *(Note 11)*:		
Cash equivalents	**$ 15,006**	$ 15,000

(Dollars in Thousands)

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

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	
	2018	**2017**
Nonoperating gains and losses:		
Interest and dividend income	**$ 8,349**	$ 8,223
Net realized gains on sales of securities	**1,938**	5,596
Investment return	**10,287**	13,819
Change in net unrealized gains and losses on trading securities	**(11,749)**	6,811
	$ (1,462)	$ 20,630

Changes in net unrealized gains and (losses) on other-than-trading securities totaled $(2,212) and $1,526 and for the years ended December 31, 2018 and 2017, respectively.

(Dollars in Thousands)

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

Liquidity Resources

The table below presents financial assets and liquidity resources available for general expenditures within one year at December 31, 2018 and 2017:

	December 31	
	2018	**2017**
Financial assets available as reported on the accompanying balance sheets:		
Cash and cash equivalents	**$ 285,926**	$ 229,850
Net patient accounts receivable	**138,860**	158,146
Current portion of assets limited to use	**28,092**	21,695
Assets limited as to use, net of current portion	**313,604**	329,082
Total financial assets available	**766,482**	738,773
Less amounts not available to be used within one year for general expenditures:		
Assets limited as to use:		
Externally designated for donor purposes	**45,904**	47,403
Externally designated under debt agreements	**12,424**	12,194
Designated under self-insurance programs	**36,889**	42,505
Externally designated – escrow agreement	**15,006**	15,000
Financial assets available and liquid to meet general expenditures within one year	**$ 656,259**	$ 621,671

The Health System has certain Board designated assets limited to use which are available for general expenditure. The Health System has other assets limited to use for donor-restricted purposes, debt agreements, self-insurance programs, and escrow agreements. As part of the Health System's liquidity management plan, cash in excess of daily requirements are invested in in short-term investments and money market funds. Assets which are not available for general expenditure within one year in the normal course of operations are excluded from the total liquidity balance in the table above.

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

Additionally, the Health System maintains a line of credit of $5,000, as described in Note 7. As of December 31, 2018 and 2017, there was $1,837 outstanding on the line of credit.

As of December 31, 2018, the Health System was in compliance with debt covenants.

Fair Value

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.

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.

(Dollars in Thousands)

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

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 $30,273 and $10,665 at December 31, 2018 and 2017, respectively), and the mark-to-market position of interest rate swap arrangements:

	Total	Level 1	Level 2	Level 3
December 31, 2018				
Assets				
Cash and cash equivalents	**$ 321,548**	**$ 321,548**	**$ –**	**$ –**
Equity securities:				
U.S. companies	**75,508**	**75,508**	**–**	**–**
International companies	**1,495**	**1,495**	**–**	**–**
Mutual funds	**12,560**	**12,560**	**–**	**–**
U.S. Treasury securities	**29,848**	**29,848**	**–**	**–**
Governmental asset-backed securities	**17,017**	**–**	**17,017**	**–**
Corporate bonds	**139,373**	**–**	**139,373**	**–**
Total assets measured at fair value	**$ 597,349**	**$ 440,959**	**$ 156,390**	**$ –**
Liabilities				
Interest rate swaps	**$ 2,747**	**$ –**	**$ 2,747**	**$ –**
Total liabilities measured at fair value	**$ 2,747**	**$ –**	**$ 2,747**	**$ –**

(Dollars in Thousands)

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

	Total	Level 1	Level 2	Level 3
December 31, 2017				
Assets				
Cash and cash equivalents	$ 270,424	$ 270,424	$ –	$ –
Equity securities:				
U.S. companies	84,683	84,683	–	–
International companies	2,224	2,224	–	–
Mutual funds	16,932	16,932	–	–
U.S. Treasury securities	32,410	32,410	–	–
Governmental asset-backed securities	13,003	–	13,003	–
Corporate bonds	150,286	–	150,286	–
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	$ –

The Health System determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets 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 2018	December 31 2017	Depreciable Life
Land	**$ 5,716**	$ 5,716	
Land improvements	**1,320**	1,320	5–25 years
Buildings and building improvements	**570,918**	527,217	10–40 years
Fixed equipment	**59,894**	58,042	10–20 years
Major movable equipment	**428,211**	413,305	5–20 years
	1,066,059	1,005,600	
Less accumulated depreciation	**(616,748)**	(564,069)	
	449,311	441,531	
Construction-in-progress	**85,045**	62,187	
	$ 534,356	$ 503,718	

Depreciation expense for the years ended December 31, 2018 and 2017, amounted to $52,780 and $49,672, respectively. Property, plant, and equipment, net included $5,312 and $6,202 of assets held under capitalized leases at December 31, 2018 and 2017, respectively.

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

The Health System capitalized net interest expense of $673 and $1,142 for the years ended December 31, 2018 and 2017, respectively.

(Dollars in Thousands)

7. Long-Term Debt

	December 31 2018	2017
2008A New Jersey Economic Development Authority (NJEDA) Variable Rate Demand Revenue Bonds, with principal payments ranging from $1,800 to $13,500 due annually beginning on November 1, 2033 through 2038, with monthly interest payments, adjusted to a weekly rate determined by the remarketing agent, not to exceed 12% (0.88% and 0.39% at December 31, 2018 and 2017, respectively)	**$ 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	**2,328**	3,337
2013A CCIA Revenue Bonds, including unamortized original issue discount of $1,513 and $1,578 at December 31, 2018 and 2017, 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	**53,402**	53,337
2014A CCIA Revenue Bonds, including unamortized original issue premium of $12,956 and $14,442 at December 31, 2018 and 2017, 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	**139,131**	145,392
Capital lease, with principal and interest payments due monthly through 2018.	**–**	103
Note payable due in monthly installments, including interest adjusted every five years per the agreement (5.75% at December 31, 2018 and 2017), maturity date of July 1, 2023, secured by the building and substantially all assets of CHCP	**270**	320

(Dollars in Thousands)

7. Long-Term Debt (continued)

	December 31	
	2018	**2017**
$8,849 capital lease, with principal and interest payments due monthly through 2028. Principal payments ranging from $171 to $1,213	**$ 7,875**	$ 8,233
NJEDA 20-year loan, with 2% interest. Repayment schedule to be finalized upon co-generation project completion	**4,723**	–
Equipment loan, ten years with 0% interest. Repayment schedule to be finalized upon co-generation project completion	**1,712**	–
Mortgage loan due in monthly installments of $220, including interest at 3.04%, through October 1, 2041	**43,262**	44,453
	302,703	305,175
Less current portion	**7,883**	7,501
Less deferred financing costs	**3,174**	3,341
Long-term debt, net of current portion	**$ 291,646**	$ 294,333

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 credit-enhanced by a letter of credit agreement from a bank, which expires on January 29, 2020, 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.

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, 2018 and 2017, the Health System has complied with these financial covenants.

(Dollars in Thousands)

7. Long-Term Debt (continued)

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:

Notional amount at December 31, 2018	$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, 2018	$(1,537)	$(1,210)
Change in fair value for the year ended December 31, 2018	$ (491)	$ (482)

During 2018 and 2017, 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 at December 31, 2018 and 2017. The collateral balance is included within prepaid expenses and other current assets on the consolidated balance sheets.

Line of Credit

The Health System has a revolving line of credit for $5,000 with a bank at December 31, 2018 and 2017. The agreement provides 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, 2019, 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, 2018 and 2017, there was $1,837 outstanding under the line of credit reported within accrued expenses.

(Dollars in Thousands)

7. Long-Term Debt (continued)

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 $288,393 and $298,590 with a carrying value of $293,116 and $296,839 at December 31, 2018 and 2017, respectively.

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 and Other	Note Payable	Total
2019	$ 7,426	$ 408	$ 49	$ 7,883
2020	7,847	507	59	8,413
2021	7,332	631	63	8,026
2022	7,550	784	68	8,402
2023	7,956	976	31	8,963
Thereafter	238,569	11,004	–	249,573
	276,680	14,310	270	291,260
Net unamortized original issue premium	11,443	–	–	11,443
	$ 288,123	$ 14,310	$ 270	$ 302,703

8. New Market Tax Credit Program

In October 2012, the Health System and CCC 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.

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, CCC entered into promissory note agreements (the Agreements) totaling $22,296 with third-party CDEs as part of the Program. CCC 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 CCC 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 CCC's agreements approximate their fair value.

9. Retirement Plans

Defined Contribution Plan

The Health System sponsors a noncontributory defined contribution retirement 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 $15,038 and $13,605 for the years ended December 31, 2018 and 2017, respectively.

(Dollars in Thousands)

9. Retirement 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	
	2018	**2017**
Change in benefit obligation		
Projected benefit obligation at beginning of year	**$ 163,522**	$ 152,540
Service cost	**1,460**	1,580
Interest cost	**5,872**	6,376
Actuarial (gain) loss	**(11,593)**	11,446
Benefits paid	**(7,097)**	(6,932)
Expected administrative expenses	**(1,235)**	(1,488)
Projected benefit obligation, end of year	**$ 150,929**	$ 163,522
Accumulated benefit obligation	**$ 150,929**	$ 163,522
Change in plan assets		
Fair value of plan assets at beginning of year	**$ 143,876**	$ 137,467
Actual return on plan assets, net of expenses	**(5,787)**	14,829
Benefits paid	**(7,097)**	(6,932)
Administrative expenses	**(1,235)**	(1,488)
Fair value of plan assets at end of year	**$ 129,757**	$ 143,876
Funded status at year-end – recognized on the consolidated balance sheets as accrued retirement benefits	**$ (21,172)**	$ (19,646)
Cumulative amounts recorded in accumulated net assets without donor restrictions consist of:		
Net unrecognized loss	**$ 38,318**	$ 39,766

(Dollars in Thousands)

9. Retirement Plans (continued)

The net unrecognized loss that will be amortized from other changes in net assets without donor restrictions into net periodic benefit cost over the next fiscal year is $3,620.

	2018	2017
Components of net periodic benefit cost and other amounts recorded in other changes in net assets without donor restrictions		
Net periodic benefit cost:		
Service cost	**$ 1,460**	$ 1,580
Interest cost	**5,872**	6,376
Expected return on plan assets	**(7,795)**	(8,239)
Recognized actuarial loss	**3,437**	3,379
	$ 2,974	$ 3,096
Other changes in pension benefit obligation recorded in other changes in net assets without donor restrictions:		
Increase (decrease) to net assets without donor restrictions	**$ 1,448**	$ (1,476)
Assumptions		
Weighted average assumptions used to determine benefit obligations at December 31:		
Discount rate	**4.34%**	3.66%
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	**3.66%**	4.24%
Expected long-term return on plan assets	**5.60%**	6.20%
Rate of compensation increase	**N/A**	N/A

(Dollars in Thousands)

9. Retirement Plans (continued)

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 5.60% and 6.20% long-term rate of return on assets assumption used in 2018 and 2017, respectively.

	Asset Allocation			December 31	
	Minimum	**Target**	**Maximum**	**2018**	**2017**
Plan assets					
Weighted average asset allocations, by asset category:					
Equity securities	30%	20%	10%	**16%**	19%
Debt securities	90	80	70	**84**	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 5.6% 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, 2018				
Money market funds	**$ 314**	**$ 314**	**$ –**	**$ –**
U.S. Treasury securities	**22,806**	**22,806**	**–**	**–**
Mutual funds	**106,637**	**106,637**	**–**	**–**
	$ 129,757	**$ 129,757**	**$ –**	**$ –**
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	$ –	$ –

(Dollars in Thousands)

9. Retirement Plans (continued)

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.

Cash Flows

Contributions

Contributions expected to be made to the Plan during 2019	$	–

Estimated Future Benefit Payments

2019	$	8,344
2020		8,882
2021		9,164
2022		9,577
2023		9,758
2024–2028		50,122

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			
	2018		**2017**	
Employee health benefits	**$**	**5,064**	$	5,592
Workers' compensation		**5,649**		5,629
Professional and general liability		**67,826**		63,692
		78,539		74,913
Less current portion of self-insured reserves		**25,421**		19,834
	$	**53,118**	$	55,079

10. Self-Insured Reserves (continued)

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.

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, 2018, 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.

(Dollars in Thousands)

10. Self-Insured Reserves (continued)

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.

11. Commitments and Contingencies

Collective-bargaining agreements

At December 31, 2018, approximately 18% of the Health System's employees are covered by collective-bargaining agreements. The collective bargaining agreements are set to expire in May 2020.

Operating Leases

The Health System rents certain equipment and buildings under various operating lease agreements. Rental expense under these lease agreements amounted to $28,630 and $27,315 in 2018 and 2017, respectively.

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

	Operating Leases
2019	$ 18,238
2020	15,819
2021	13,645
2022	11,097
2023	9,723
Thereafter	36,588

11. Commitments and Contingencies (continued)

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 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 any issues which have not been accrued at December 31, 2018, 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, 2018 and 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.

(Dollars in Thousands)

12. Net Assets with Donor Restrictions

Net assets with donor restrictions are as follows:

	December 31	
	2018	**2017**
Purpose – various funds for benefit of the departments, programs, or educational programs of the Health System	**$ 37,827**	$ 31,465
Time restricted – pledges	**441**	440
Permanent endowments – to be maintained in perpetuity	**2,585**	2,464
Total net assets with donor restrictions	**$ 40,853**	$ 34,369

The Health System follows the requirements of Uniform Prudent Management of Institutional Funds Act (UPMIFA) as they relate to its permanent 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.

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. The original value of such gifts and subsequent gifts are classified as net assets with donor restrictions – permanent endowment. Accumulated earnings of the permanent endowment are to be used in accordance with the direction of the applicable donor gift. The remaining portion of the endowment fund that is not required to be maintained in perpetuity is characterized as restricted for time or purpose until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA.

(Dollars in Thousands)

12. Net Assets with Donor Restrictions (continued)

Endowments to be maintained in perpetuity consist of the following:

	December 31 2018	2017
Women's Board	**$ 1,029**	$ 1,012
Radiology	**501**	501
Lummis Trust	**218**	204
Nursing education	**171**	171
Cleft Palate program	**107**	106
Nispel Estate	**16**	16
Physical teaching and excellence award	**13**	13
Other	**530**	441
Total endowments	**$ 2,585**	$ 2,464

The investment income earned on the above endowments is to be used to support patient care services, with the exception of the Nispel Estate and the Lummis Trust, for which the investment income is without restrictions.

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.

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

	Year Ended December 31 2018	2017
Purpose:		
Various funds for benefit of the departments, programs, or educational programs of the Health System	**$ 421**	$ 2,792
	$ 421	$ 2,792

(Dollars in Thousands)

13. Other Revenue

Other revenue consists of the following:

	Year Ended December 31	
	2018	**2017**
Grant revenue	**$ 19,843**	$ 16,537
Medical school support	**2,800**	3,388
Grow NJ tax credits	**3,820**	4,236
Food services	**6,546**	5,869
Centers for population health	**1,642**	1,721
Retail pharmacy cost sharing	**13,193**	7,619
Physician services	**16,293**	16,355
Emergency/air transport	**7,588**	7,538
Net assets released from restrictions for operating purposes	**421**	2,792
Other	**11,201**	10,775
	$ 83,347	$ 76,830

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 $3,820 and $4,236 in the years ended December 2018 and 2017, respectively, which was recorded in other revenue on the consolidated statements of operations and change in net assets.

(Dollars in Thousands)

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:

	Health Care Services	Physician Services	General and Administrative	Total
Year ended December 31, 2018				
Salaries, wage, and fringe benefits	**$ 259,259**	**$ 351,573**	**$ 141,133**	**$ 751,965**
Supplies and other	**391,904**	**2,318**	**27,914**	**422,136**
Malpractice	**–**	**10,271**	**14,617**	**24,888**
Depreciation and amortization	**–**	**2,234**	**49,292**	**51,526**
Interest	**–**	**–**	**14,208**	**14,208**
	$ 651,163	**$ 366,396**	**$ 247,164**	**$ 1,264,723**
Year ended December 31, 2017				
Salaries, wage, and fringe benefits	$ 243,080	$ 333,682	$ 137,838	$ 714,600
Supplies and other	362,243	3,762	36,675	402,680
Malpractice	–	9,041	8,851	17,892
Depreciation and amortization	–	2,536	46,025	48,561
Interest	–	–	14,138	14,138
	$ 605,323	$ 349,021	$ 243,527	$ 1,197,871

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 $2,391 and $4,522 of state appropriation during the years ended December 31, 2018 and 2017, respectively.

16. Subsequent Events

The Health System has evaluated subsequent events through April 29, 2019, 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, 2018

	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	$ 261,500	$ 144	$ –	$ 261,644	$ 10,297	$ –	$ –	$ 13,985	$ –	$ 285,926
Current portion of assets limited as to use	28,092	–	–	28,092	–	–	–	–	–	28,092
Patient accounts receivable, net	138,860	–	–	138,860	–	–	–	–	–	138,860
Prepaid expenses and other current assets	50,525	2,311	(2,311)	50,525	17	976	–	–	–	51,518
Due from affiliates	7,460	9,445	(9,445)	7,460	–	727	–	–	(8,187)	–
Total current assets	486,437	11,900	(11,756)	486,581	10,314	1,703	–	13,985	(8,187)	504,396
Assets limited as to use:										
Internally designated by Board of Trustees	231,473	–	–	231,473	–	–	–	–	–	231,473
Externally designated for donor purposes	–	–	–	–	45,904	–	–	–	–	45,904
Externally designated under debt agreements, net of current portion	3,807	–	–	3,807	–	–	–	–	–	3,807
Externally designated – escrow agreement	15,006	–	–	15,006	–	–	–	–	–	15,006
Designated under self-insurance programs, net of current portion	17,414	–	–	17,414	–	–	–	–	–	17,414
Assets limited as to use, net of current portion	267,700	–	–	267,700	45,904	–	–	–	–	313,604
Property, plant, and equipment, net	482,676	38,193	–	520,869	–	–	914	12,573	–	534,356
Other assets, net	1,171	721	–	1,892	463	–	4,954	–	–	7,309
Notes receivable	15,781	–	–	15,781	–	–	–	–	–	15,781
Due from affiliates	–	–	–	–	–	–	–	31,422	(31,422)	–
Total assets	$ 1,253,765	$ 50,814	$ (11,756)	$ 1,292,823	$ 56,681	$ 1,703	$ 5,868	$ 57,980	$ (39,609)	$ 1,375,446
Liabilities and net assets										
Current liabilities:										
Accounts payable	$ 27,305	$ –	$ –	$ 27,305	$ –	$ –	$ –	$ –	$ –	$ 27,305
Accrued expenses	131,558	–	–	131,558	700	974	7	733	–	133,972
Current portion of estimated settlements due to third-party payors	354	–	–	354	–	–	–	–	–	354
Current portion of self-insured reserves	25,421	–	–	25,421	–	–	–	–	–	25,421
Current portion of long-term debt	6,507	–	–	6,507	–	–	49	1,327	–	7,883
Due to affiliates	9,445	–	(9,445)	–	5,546	–	2,519	122	(8,187)	–
Total current liabilities	200,590	–	(9,445)	191,145	6,246	974	2,575	2,182	(8,187)	194,935
Estimated settlements due to third-party payors, net of current portion	5,548	–	–	5,548	–	–	–	–	–	5,548
Accrued retirement benefits	21,172	–	–	21,172	–	–	–	–	–	21,172
Self-insured reserves, net of current portion	53,118	–	–	53,118	–	–	–	–	–	53,118
Long-term debt, net of current portion	249,579	–	–	249,579	–	–	221	41,846	–	291,646
Deferred revenue and other liabilities	14,587	–	(2,311)	12,276	–	–	–	2,242	–	14,518
Due to affiliates	31,422	–	–	31,422	–	–	–	–	(31,422)	–
Notes payable	–	22,296	–	22,296	–	–	–	–	–	22,296
Total liabilities	576,016	22,296	(11,756)	586,556	6,246	974	2,796	46,270	(39,609)	603,233
Net assets:										
Without donor restrictions	677,310	28,518	–	705,828	10,021	729	3,072	11,710	–	731,360
With donor restrictions	439	–	–	439	40,414	–	–	–	–	40,853
Total net assets	677,749	28,518	–	706,267	50,435	729	3,072	11,710	–	772,213
Total liabilities and net assets	$ 1,253,765	$ 50,814	$ (11,756)	$ 1,292,823	$ 56,681	$ 1,703	$ 5,868	$ 57,980	$ (39,609)	$ 1,375,446

The Cooper Health System

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

Year Ended December 31, 2018

	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
Net assets without donor restrictions										
Revenue:										
Net patient service revenue	$ 1,209,359	$ –	$ –	$ 1,209,359	$ –	$ –	$ –	$ –	$ –	$ 1,209,359
Other revenue	83,856	1,380	(1,380)	83,856	776	1,223	634	7,547	(10,689)	83,347
Total revenue	1,293,215	1,380	(1,380)	1,293,215	776	1,223	634	7,547	(10,689)	1,292,706
Expenses:										
Salaries, wages, and fringe benefits	751,312	–	–	751,312	–	653	–	–	–	751,965
Supplies and other	425,511	130	(1,380)	424,261	3,447	551	433	4,133	(10,689)	422,136
Malpractice	24,888	–	–	24,888	–	–	–	–	–	24,888
Depreciation and amortization	47,234	3,162	–	50,396	–	–	41	1,089	–	51,526
Interest	12,566	269	–	12,835	–	–	18	1,355	–	14,208
Total expenses	1,261,511	3,561	(1,380)	1,263,692	3,447	1,204	492	6,577	(10,689)	1,264,723
Operating income (loss)	31,704	(2,181)	–	29,523	(2,671)	19	142	970	–	27,983
Nonoperating gains and losses:										
Transaction-related costs	(350)	–	–	(350)	–	–	–	–	–	(350)
Investment return	9,322	–	–	9,322	965	–	–	–	–	10,287
Net change in unrealized gains and losses on trading securities	(7,993)	–	–	(7,993)	(3,756)	–	–	–	–	(11,749)
Change in value of equity method investments	(1,325)	–	–	(1,325)	–	–	–	935	–	(390)
Change in fair value of interest rate swap agreements	973	–	–	973	–	–	–	–	–	973
Excess (deficiency) of revenue over expenses	32,331	(2,181)	–	30,150	(5,462)	19	142	1,905	–	26,754
Other changes in net assets without donor restrictions:										
Change in pension benefit obligation	1,448	–	–	1,448	–	–	–	–	–	1,448
Contributions received and expended for capital acquisitions	22,087	–	–	22,087	–	–	–	–	–	22,087
Net change in unrealized gains and losses on other-than-trading securities	(2,212)	–	–	(2,212)	–	–	–	–	–	(2,212)
Increase (decrease) in net assets without donor restrictions	53,654	(2,181)	–	51,473	(5,462)	19	142	1,905	–	48,077
Net assets with donor restrictions										
Contributions, gifts, and special events, net of fundraising expenses	–	–	–	–	5,561	–	–	–	–	5,561
Income from investments	–	–	–	–	507	–	–	–	–	507
Net realized and unrealized gains on investments	–	–	–	–	837	–	–	–	–	837
Net assets released from restrictions for operating purposes	–	–	–	–	(421)	–	–	–	–	(421)
Increase in net assets with donor restrictions	–	–	–	–	6,484	–	–	–	–	6,484
Increase (decrease) in net assets	53,654	(2,181)		51,473	1,022	19	142	1,905		54,561
Net assets, beginning of year	624,095	30,699	–	654,794	49,413	710	2,930	9,805	–	717,652
Net assets, end of year	$ 677,749	$ 28,518	$ –	$ 706,267	$ 50,435	$ 729	$ 3,072	$ 11,710	$ –	$ 772,213

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