Consolidated Financial Statements and Supplementary Information

The Cooper Health System
Years Ended December 31, 2019 and 2018
With Report of Independent Auditors

Ernst & Young LLP

The Cooper Health System

Consolidated Financial Statements
and Supplementary Information

Years Ended December 31, 2019 and 2018

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, 2019 and 2018, 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, 2019 and 2018, 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. 2016-02, *Leases*

As discussed in Note 2 to the consolidated financial statements, the Health System changed its method of accounting for leases as a result of the adoption of the amendments to the Financial Accounting Standards Board Accounting Standards Codification resulting from Accounting Standards Update No. 2016-02, *Leases*, effective January 1, 2019. Our opinion is not modified with respect to this matter.

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, 2019, 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 23, 2020

The Cooper Health System

Consolidated Balance Sheets
(In Thousands)

	December 31 2019	2018
Assets		
Current assets:		
Cash and cash equivalents	**$ 360,290**	$ 285,926
Current portion of assets limited as to use	**28,374**	28,092
Patient accounts receivable, net	**146,719**	138,860
Prepaid expenses and other current assets	**49,882**	51,518
Total current assets	**585,265**	504,396
Assets limited as to use:		
Internally designated by Board of Trustees	**256,377**	231,473
Externally designated for donor purposes	**54,808**	45,904
Externally designated under debt agreements, net of current portion	**3,866**	3,807
Externally designated – escrow agreement	**15,011**	15,006
Designated under self-insurance programs, net of current portion	**25,790**	17,414
Assets limited as to use, net of current portion	**355,852**	313,604
Property, plant, and equipment, net	**600,228**	534,356
Operating lease assets, net	**56,513**	–
Other assets, net	**12,997**	7,309
Notes receivable	**–**	15,781
Total assets	**$ 1,610,855**	$ 1,375,446

	December 31	
	2019	**2018**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 56,092**	$ 27,305
Accrued expenses	**143,770**	132,135
Current portion of estimated settlements due to third-party payors	**342**	354
Current portion of self-insured reserves	**26,363**	25,421
Current portion of long-term debt	**8,226**	7,883
Current portion of operating lease liability	**15,239**	–
Line of credit advances	**41,000**	1,837
Total current liabilities	**291,032**	194,935
Estimated settlements due to third-party payors, net of current portion	**11,145**	5,548
Accrued retirement benefits	**19,032**	21,172
Self-insured reserves, net of current portion	**62,303**	53,118
Long-term debt, net of current portion	**286,189**	291,646
Operating lease liability, net of current portion	**42,442**	–
Deferred revenue and other liabilities	**21,062**	14,518
Notes payable	**–**	22,296
Total liabilities	**733,205**	603,233
Net assets:		
Without donor restrictions	**829,493**	731,360
With donor restrictions	**48,157**	40,853
Total net assets	**877,650**	772,213
Total liabilities and net assets	**$ 1,610,855**	$ 1,375,446

See accompanying notes.

The Cooper Health System

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

	Year Ended December 31 2019	2018
Net assets without donor restrictions		
Revenue:		
Net patient service revenue	**$ 1,355,977**	$ 1,209,359
Other revenue	**83,435**	83,347
Total revenue	**1,439,412**	1,292,706
Expenses:		
Salaries, wages, and fringe benefits	**819,345**	748,991
Supplies and other	**474,674**	422,136
Malpractice	**30,410**	24,888
Depreciation and amortization	**55,797**	51,526
Interest	**13,622**	14,208
Total expenses	**1,393,848**	1,261,749
Operating income	**45,564**	30,957
Nonoperating gains and (losses):		
Investment return	**25,512**	10,287
Net change in unrealized gains and (losses) on trading securities	**10,564**	(11,749)
Net change in unrealized gains and (losses) on other-than-trading equity securities	**2,619**	–
Gain on forgiveness of note payable	**6,515**	–
Change in value of equity method investments	**998**	(390)
Net periodic pension cost	**(14,716)**	(2,974)
Change in fair value of interest rate swap agreements	**(1,526)**	973
Other losses	**(5,129)**	(350)
Excess of revenue over expenses	**70,401**	26,754
Other changes in net assets without donor restrictions:		
Change in pension benefit obligation	**11,439**	1,448
Contributions received and expended for capital acquisitions	**13,365**	22,087
Net change in unrealized gains and (losses) on fixed-income other-than-trading securities	**2,928**	–
Net change in unrealized gains and (losses) on other-than-trading securities	**–**	(2,212)
Increase in net assets without donor restrictions	**98,133**	48,077

The Cooper Health System

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

	Year Ended December 31 2019	2018
Net assets with donor restrictions		
Contributions, gifts, and special events, net of fundraising expenses	**$ 4,451**	$ 5,561
Income from investments	**1,009**	507
Net realized and unrealized gains on investments	**1,844**	837
Net assets released from restrictions for operating purposes	**–**	(421)
Increase in net assets with donor restrictions	**7,304**	6,484
Increase in net assets	**105,437**	54,561
Net assets, at beginning of year	**772,213**	717,652
Net assets, at end of year	**$ 877,650**	$ 772,213

See accompanying notes.

The Cooper Health System

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended December 31 2019	2018
Operating activities		
Increase in net assets	**$ 105,437**	$ 54,561
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Change in pension benefit obligation	**(11,439)**	(1,448)
Change in fair value of interest rate swap agreements	**1,526**	(973)
Depreciation and amortization	**55,797**	51,526
Net realized and unrealized gains and losses on investments	**(30,690)**	11,186
Change in value of equity method investments	**(998)**	390
Gain on forgiveness of note payable	**(6,515)**	–
Contributions for capital acquisitions	**(13,365)**	(22,087)
Changes in certain assets and liabilities:		
Patient accounts receivable	**(7,859)**	19,286
Prepaid expenses and other assets	**(1,886)**	(3,748)
Accounts payable and accrued expenses	**40,422**	12,826
Self-insured reserves and accrued retirement benefits	**19,426**	6,600
Estimated settlements with third-party payers	**5,585**	(2,594)
Deferred revenue and other liabilities	**5,018**	(1,044)
Net cash provided by operating activities	**160,459**	124,481
Investing activities		
Purchases of assets limited as to use	**(11,570)**	(1,869)
Acquisition of equity method investment	**–**	(3,918)
Capital expenditures, net	**(122,773)**	(83,418)
Net cash used in investing activities	**(134,343)**	(89,205)
Financing activities		
Repayments of long-term debt	**(7,876)**	(7,486)
Proceeds from long-term debt	**3,866**	6,435
Repayments of line of credit advances	**(1,837)**	–
Proceeds from line of credit advances	**41,000**	–
Contributions for capital acquisitions	**13,365**	22,087
Net cash provided by financing activities	**48,518**	21,036
Net increase in cash and cash equivalents and restricted cash and restricted cash equivalents	**74,634**	56,312
Cash and cash equivalents and restricted cash and restricted cash equivalents at beginning of year	**313,356**	257,044
Cash and cash equivalents and restricted cash and restricted cash equivalents at end of year	**$ 387,990**	$ 313,356
Supplemental disclosure of cash flow information		
Cash paid for interest	**$ 14,406**	$ 14,954

See accompanying notes.

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 2019 or 2018.

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. Although these entities have been consolidated for financial statement reporting purposes, there may be limitations on the use of an entity's funds by another member of the group resulting from the charitable nature of some of the entities or other factors.

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.

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 cash equivalents classified as assets limited as to use designated by the Board of Trustees, donors and for self-insurance programs as such holdings are within investment portfolios. The Health System does not hold any money market funds with significant liquidity restrictions that would be required to be excluded from cash equivalents.

(Dollars in Thousands)

2. Summary of Significant Accounting Policies (continued)

The following is a reconciliation of amounts reported on the consolidated balance sheets to the statement of cash flows as of and for the year ended December 31, 2019 and 2018:

	2019	2018
Cash and cash equivalents	**$ 360,290**	$ 285,926
Assets limited as to use: cash and cash equivalents	**27,700**	27,430
Total cash and cash equivalents and restricted cash and restricted cash equivalents	**$ 387,990**	$ 313,356

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, inclusive of provisions for variable consideration such as contractual adjustments, discounts, implicit price concessions and other reductions to the Health System's standard charges. An allowance for doubtful accounts is recorded 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.

Derivative Financial Instruments

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 for certain outstanding debt and prospective transactions. The 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

2. Summary of Significant Accounting Policies (continued)

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 12) 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 (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.

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, realized gains and losses, the change in unrealized gains and losses on trading securities, including equity in income on alternative investments, and the change in unrealized gains and losses on other than

2. Summary of Significant Accounting Policies (continued)

trading equity securities, 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 fixed income 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 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.

2. Summary of Significant Accounting Policies (continued)

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 finance 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, 2019 or 2018.

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)

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 2019 and 2018, the Health System incurred advertising expenses of $5,938 and $7,537, respectively, which are included in supplies and other expense on the consolidated statements of operations and changes in net assets.

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 fixed income 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.

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.

2. Summary of Significant Accounting Policies (continued)

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.

The Health System recognizes government grants where commensurate value is not exchanged as contributions when conditions and restrictions are satisfied and reports such amounts within other revenue.

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.

The Taxpayer Certainty and Disaster Tax Relief Act of 2019, signed into law on December 20, 2019, retroactively repealed Code Section 512(a)(7) which subjected amounts paid or incurred by an exempt organization to provide certain transportation fringe benefits to its employees to taxation as unrelated business taxable income. Prior year income tax payments, as well as current year payments for income taxes associated with Code Section 512(a)(7) for which refunds have been requested are recorded as receivables at December 31, 2019. These amounts are not significant to the accompanying consolidated financial statements.

Reclassifications

Certain reclassifications have been made to 2018 amounts previously reported in order to conform to the current year presentation. These reclassifications had no impact on the previously reported net assets.

2. Summary of Significant Accounting Policies (continued)

Recent Accounting Pronouncements

Adopted Changes

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. (ASU) 2016-02, *Leases*, which requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the statements of financial position, including both finance leases (formerly referred to as capital leases) and operating leases. ASU 2016-02 requires expanded disclosure related to lease agreements (see Note 7) to help the financial statement users better understand the amount, timing, and uncertainty of cash flows arising from leases. The recognition, measurement and presentation of expenses and cash flows arising from a lease primarily depends on its classification as a finance or operating lease. The Health System adopted ASU 2016-02 effective January 1, 2019, following the modified retrospective method of application. As such, the 2018 consolidated financial statement amounts and disclosures have not been adjusted to reflect the provisions of the new standard. There was no cumulative-effect impact to the 2018 consolidated net assets as a result of the adoption. The Health System has made the transition-specific election to apply the package of practical expedients which allows for the carryforward of historical assessments of (1) whether contracts are or contain leases, (2) lease classification and (3) initial direct costs. Additionally, for operating leases entered into prior to January 1, 2019, the Health System has elected to utilize the operating leases' remaining lease term as of the date of adoption to determine the discount rate used to initially measure the liability. Certain other accounting policy elections and quantitative and qualitative information pertaining to the Health System's adoption of ASU 2016-02 are described in Note 7.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall: Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU 2016-01 requires 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. The Health System adopted ASU 2016-01 in 2019, and will no longer be able to recognize unrealized gains and losses on equity securities classified as other-than-trading outside of the performance indicator. ASU 2016-01 also contains a provision

2. Summary of Significant Accounting Policies (continued)

that eliminates the requirement for the Health System to disclose the fair value of financial instruments measured at amortized cost. This ASU did not impact the accounting for investments in debt securities. The impact of this adoption did not have a material impact on the Health System's consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows – Classification of Certain Cash Receipts and Cash Payments*, which addresses the following eight specific cash flow issues in order to limit diversity in practice: debt prepayment or debt extinguishment costs; settlement of zero-coupon debt instruments or other debt instruments with coupon interest rates that are insignificant in relation to the effective interest rate of the borrowing; contingent consideration payments made after a business combination; proceeds from the settlement of 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 Health System adopted ASU 2016-15 for the year ended December 31, 2019, and the adoption did not have a material impact on the Health System's consolidated financial statements.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows – Restricted Cash*, which requires that the statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The Health System adopted ASU 2016-18 using a retrospective transition method.

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 in the income statement. Employers are 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 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 Health System adopted ASU 2017-07 in 2019 and the effects of the adoption of

2. Summary of Significant Accounting Policies (continued)

ASU 2017-07 were applied retrospectively. The adoption required the Health System to present the non-service cost components of net periodic benefit costs (aggregate of $14,716 and $2,974 for 2019 and 2018, respectively) as a separate line item excluded from the subtotal for operating income 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 (or a right of release of the promisor's obligation to transfer the assets). The standard was applied on a modified prospective basis to agreements that were not completed as of the effective date and to agreements entered into after the effective date. The Health System adopted ASU 2018-08 effective January 1, 2019. The adoption of ASU 2018-08 did not have a material impact to the Health System's consolidated financial statements.

Pending Changes

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,

2. Summary of Significant Accounting Policies (continued)

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 2018-13, *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*. 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 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 2018-13: 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.

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*. The main objective of ASU 2016-13 and related ASU updates is to provide financial statement users with more decision-useful information about the expected credit losses on financial instruments and other commitments to extend credit held by a reporting entity at each reporting date. The amendments affect loans, debt securities, trade receivables, net investments in leases, off balance sheet credit exposures, reinsurance receivables, and any other financial assets not excluded from the scope that have the contractual right to receive cash. The amendments in this Update are effective for the Health System for fiscal years beginning after December 15, 2022. The Health System is in the process of evaluating the impact of ASU 2018-15 on its consolidated financial statements.

3. Net Patient Service Revenue

Accounts Receivable and Net Patient Service Revenue

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 provisions for variable consideration (reductions to revenue) for retroactive revenue adjustments including 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.

The Health System's initial estimate of the transaction price for services provided to patients 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.

3. Net Patient Service Revenue (continued)

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.

Substantially all of its performance obligations relate to contracts with a duration of less than one year. Unsatisfied or partially unsatisfied performance obligations primarily relate 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 years ended December 31, 2019 and 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 years ended December 31, 2019 and 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.

(Dollars in Thousands)

3. Net Patient Service Revenue (continued)

Net patient service revenue recognized in the period from these major payor sources, based on primary insurance designation, is as follows:

	Year Ended December 31	
	2019	**2018**
Medicare	**$ 425,258**	$ 416,189
Medicaid	**299,974**	268,382
Commercial carriers and health maintenance organizations	**572,500**	477,090
State subsidies *(Note 4)*	**22,632**	20,533
Self-pay	**35,613**	27,165
	$ 1,355,977	$ 1,209,359

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 by line of business is as follows:

	Year Ended December 31	
	2019	**2018**
Hospital	**$ 1,041,043**	$ 928,587
Physician services	**314,934**	280,772
	$ 1,355,977	$ 1,209,359

Accounts receivable is comprised of the following components:

	December 31	
	2019	**2018**
Patient receivables	**$ 132,439**	$ 127,222
Contract assets	**14,280**	11,638
	$ 146,719	$ 138,860

3. Net Patient Service Revenue (continued)

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.

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 2017 have been settled by Medicare and the cost report for fiscal year 2018 has 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.

Settlements with third-party payors 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 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.

3. Net Patient Service Revenue (continued)

During 2019 and 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. The net effect of the Health System's revisions to prior year estimates resulted in net patient service revenue increasing by approximately $1,690 and decreasing by approximately $4,000 for the years ended December 31, 2019 and 2018, respectively.

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	
	2019	**2018**
Commercial	**24%**	23%
Health maintenance organizations	**43**	38
Medicare	**15**	18
Blue Cross	**13**	15
Self-pay (including accounts which may ultimately be charity care)	**3**	3
Medicaid	**2**	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 $29,630 and $27,671 for the years ended December 31, 2019 and 2018, respectively.

(Dollars in Thousands)

4. Charity Care and State Subsidies (continued)

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 patients who were determined by the Health System to have the ability to pay but did not, the expected uncollected amounts are classified as an implicit price concession which directly reduces net patient service revenue. Distinguishing between charity care and implicit price concessions is difficult, in part because services are often rendered prior to the Health System's full evaluation of the patient's ability to pay.

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	
	2019	**2018**
Charity Care Subsidy Fund	**$ 14,668**	$ 13,546
Delivery System Reform Incentive Payment Pool	**7,964**	6,987
	$ 22,632	$ 20,533

(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	
	2019	**2018**
Internally designated by Board of Trustees:		
Cash and cash equivalents	**$ 6,572**	$ 5,522
Equity securities:		
U.S. companies	**66,386**	49,966
International companies	**–**	1,495
U.S. Treasury securities	**6,735**	13,412
Governmental asset-backed securities	**16,922**	8,900
Mutual funds	**6,572**	5,396
Alternative investments, at equity method value	**21,478**	30,273
Corporate bonds	**131,712**	116,509
	$ 256,377	$ 231,473
Externally designated for donor purposes:		
Cash and cash equivalents	**$ 374**	$ 907
U.S. equity securities	**33,095**	25,542
U.S. Treasury securities	**11,132**	11,345
Governmental asset-backed securities	**735**	–
Corporate bonds	**9,472**	8,110
	$ 54,808	$ 45,904
Externally designated – under debt agreements:		
Cash and cash equivalents	**$ 12,689**	$ 12,424
Less current portion	**8,823**	8,617
	$ 3,866	$ 3,807

(Dollars in Thousands)

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

	December 31	
	2019	**2018**
Assets held under debt agreements are maintained for the following purposes:		
Debt service interest funds	**$ 3,856**	$ 3,962
Debt service principal funds	**4,966**	4,655
Debt service reserve funds	**264**	261
Capital addition funds	**3,603**	3,546
	$ 12,689	$ 12,424
Externally designated – escrow agreement *(Note 11)*:		
Cash equivalents	**$ 15,011**	$ 15,006
Designated – under self-insurance programs:		
Cash and cash equivalents	**$ 2,053**	$ 1,763
U.S. Treasury securities	**5,186**	5,091
Governmental asset-backed securities	**740**	8,117
Mutual funds	**14,008**	7,164
Corporate bonds	**23,354**	14,754
	45,341	36,889
Less current portion	**19,551**	19,475
	$ 25,790	$ 17,414

(Dollars in Thousands)

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

Investment return, net of amounts capitalized, and net change in unrealized gains and losses which are included in nonoperating gains and losses are comprised of the following:

	Year Ended December 31	
	2019	**2018**
Nonoperating gains and losses:		
Interest and dividend income	**$ 12,777**	$ 8,349
Net realized gains on sales of securities	**12,735**	1,938
Investment return	**25,512**	10,287
Net change in net unrealized gains and losses on other than trading equity securities	**2,619**	–
Net change in net unrealized gains and losses on trading securities	**10,564**	(11,749)
	$ 38,695	$ (1,462)

Net changes in net unrealized gains and (losses) on other-than-trading securities (fixed income securities in 2019; fixed income and equity securities in 2018 prior to the adoption of ASU 2016-01) totaled $2,928 and $(2,212) and for the years ended December 31, 2019 and 2018, 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:

	December 31 2019	2018
Financial assets available as reported on the accompanying balance sheets:		
Cash and cash equivalents	**$ 360,290**	$ 285,926
Net patient accounts receivable	**146,719**	138,860
Current portion of assets limited to use	**28,374**	28,092
Assets limited as to use, net of current portion	**355,852**	313,604
Total financial assets available	**891,235**	766,482
Less amounts not available to be used within one year for general expenditures:		
Assets limited as to use:		
Externally designated for donor purposes	**54,808**	45,904
Externally designated under debt agreements	**12,689**	12,424
Externally designated – escrow agreement	**15,011**	15,006
Designated under self-insurance programs	**45,341**	36,889
Financial assets available and liquid to meet general expenditures within one year	**$ 763,386**	$ 656,259

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 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 lines of credit totaling $130,000, as described in Note 8. As of December 31, 2019 and 2018, there was $41,000 and $1,837 outstanding on the line of credit, respectively.

As of December 31, 2019, 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 $21,478 and $30,273 at December 31, 2019 and 2018, respectively), and the mark-to-market position of interest rate swap arrangements:

	Total	Level 1	Level 2	Level 3
December 31, 2019				
Assets				
Cash and cash equivalents	**$ 396,989**	**$ 396,989**	**$ –**	**$ –**
U.S. equity securities	**99,481**	**99,481**		
Mutual funds	**20,580**	**20,580**	**–**	**–**
U.S. Treasury securities	**23,053**	**23,053**	**–**	**–**
Governmental asset-backed securities	**18,397**	**–**	**18,397**	**–**
Corporate bonds	**164,538**	**–**	**164,538**	**–**
Total assets measured at fair value	**$ 723,038**	**$ 540,103**	**$ 182,935**	**$ –**
Liabilities				
Interest rate swaps	**$ 4,273**	**$ –**	**$ 4,273**	**$ –**
Total liabilities measured at fair value	**$ 4,273**	**$ –**	**$ 4,273**	**$ –**

(Dollars in Thousands)

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

	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	$ –

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, 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 2019	December 31 2018	Depreciable Life
Land	**$ 5,716**	$ 5,716	
Land improvements	**1,320**	1,320	5–25 years
Buildings and building improvements	**585,093**	570,918	10–40 years
Fixed equipment	**90,417**	59,894	10–20 years
Major movable equipment	**449,361**	428,211	5–20 years
	1,131,907	1,066,059	
Less accumulated depreciation	**(673,152)**	(616,748)	
	458,755	449,311	
Construction-in-progress	**141,473**	85,045	
	$ 600,228	$ 534,356	

Depreciation expense for the years ended December 31, 2019 and 2018, amounted to $56,901 and $52,780, respectively. Property, plant, and equipment, net included $4,498 and $5,312 of assets held under finance leases at December 31, 2019 and 2018, respectively.

The Health System capitalized net interest expense of $679 and $673 for the years ended December 31, 2019 and 2018, respectively.

7. Leases

As described in Note 2, the Health System adopted ASU 2016-02 effective January 1, 2019. The Health System leases certain property and equipment under finance and operating leases. Leases are classified as either finance or operating leases based on the underlying terms of the agreement and certain criteria, such as the term of the lease relative to the useful life of the asset and the total lease payments to be made as compared to the fair value of the asset, amongst other criteria. Finance leases result in an accounting treatment similar to an acquisition of the asset.

7. Leases (continued)

For leases with initial terms greater than a year (or initially greater than one year remaining under the lease at the date of adoption of ASU 2016-02), the Health System records the related right-of-use assets and liabilities at the present value of the lease payments to be paid over the life of the related lease. The Health System's leases may include variable lease payments and renewal options. Variable lease payments are excluded from the amounts used to determine the right-of-use assets and liabilities unless the variable lease payments depend on an index or rate or are in substance fixed payments. Lease payments related to periods subject to renewal options are also excluded from the amounts used to determine the right-of-use assets and liabilities unless the Health System is reasonably certain to exercise the option to extend the lease. The present value of lease payments is calculated by utilizing the discount rate stated in the lease, when readily determinable. For leases for which this rate is not readily available, the Health System has elected to use a risk-free discount rate determined using a period comparable with that of the lease term. The Health System has made an accounting policy election to separate lease components from nonlease components in contracts when determining its lease payments for its asset classes except for medical equipment, as permitted by ASU 2016-02. As such, the Health System does not account for the applicable nonlease components together with the related lease components when determining the right-of-use assets and liabilities, except for medical equipment.

The Health System has made an accounting policy election not to record leases with an initial term of less than a year as right-of-use assets and liabilities.

Operating leases with a present value of approximately $70,067 were recorded as right-of-use liabilities and assets as of January 1, 2019, upon the adoption of ASU 2016-02.

(Dollars in Thousands)

7. Leases (continued)

The following schedule summarizes information related to the lease assets and liabilities as of and for the year ended December 31, 2019:

Lease cost for the year ended December 31, 2019:		
Finance lease cost:		
Amortization of right-of-use asset	$	814
Interest on lease liabilities		1,693
Operating lease cost		16,330
Short-term lease cost		9,860
Total lease cost	$	28,697
Right-of-use assets and liabilities as of December 31, 2019:		
Right-of-use assets – finance leases	$	4,498
Lease liability – finance leases		7,467
Right-of-use assets – operating leases		56,513
Lease liability – operating leases		57,681
Other information:		
Cash paid for amounts included in the measurement of lease liabilities (year ended December 31, 2019):		
Operating cash flows from finance leases	$	1,693
Operating cash flows from operating leases		16,065
Financing cash flows from finance leases		408
Right-of-use assets obtained in exchange for new finance lease liabilities (year ended December 31, 2019)	$	–
Right-of-use assets obtained in exchange for new operating lease liabilities (year ended December 31, 2019)	$	3,679
Weighted average remaining lease term – finance leases		12.00
Weighted average remaining lease term – operating leases		4.72
Weighted average discount rate – finance leases		3.04%
Weighted average discount rate – operating leases		1.41%

(Dollars in Thousands)

7. Leases (continued)

For finance leases, right-of-use assets are recorded in property, buildings and equipment and lease liabilities are recorded in long-term debt in the accompanying consolidated balance sheets. For operating leases, right-of-use assets are recorded in operating lease assets, net and lease liabilities are recorded in operating lease liability, current and noncurrent in the accompanying consolidated balance sheets.

The following table reconciles the undiscounted lease payments to the lease liabilities recorded on the accompanying consolidated balance sheet at December 31, 2019:

	Finance Leases	Operating Leases
2019	$ 2,101	$ 15,981
2020	2,101	15,435
2021	2,101	13,207
2022	2,101	5,547
2023	2,101	3,911
Thereafter	5,561	6,402
Total lease payments	16,066	60,483
Less imputed interest	(8,599)	(2,802)
Total lease obligation	7,467	57,681
Less current portion	507	15,239
Long-term portion	$ 6,960	$ 42,442

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 (the right of use asset and liability are reflected in the amounts above). 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.

(Dollars in Thousands)

8. Long-Term Debt and Lines of Credit

	December 31 2019	2018
2008A New Jersey Economic Development Authority (NJEDA) Variable Rate Demand Revenue Bonds, with principal payments ranging from $1,800 to $13,500 due annually beginning on November 1, 2033, through 2038, with monthly interest payments, adjusted to a weekly rate determined by the remarketing agent, not to exceed 12% (1.05% and 0.88% at December 31, 2019 and 2018, respectively)	**$ 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	**1,278**	2,328
2013A CCIA Revenue Bonds, including unamortized original issue discount of $1,448 and $1,513 at December 31, 2019 and 2018, 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	**53,467**	53,402
2014A CCIA Revenue Bonds, including unamortized original issue premium of $11,529 and $12,956 at December 31, 2019 and 2018, 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	**132,654**	139,131
Note payable due in monthly installments, including interest adjusted every five years per the agreement (5.75% at December 31, 2019 and 2018), maturity date of July 1, 2023, secured by the building and substantially all assets of CHCP	**217**	270

(Dollars in Thousands)

8. Long-Term Debt and Lines of Credit (continued)

	December 31 2019	2018
$8,849 finance lease, with principal and interest payments due monthly through 2028. Remaining principal payments ranging from $507 to $990	**$ 7,467**	$ 7,875
NJEDA 20-year loan, with 2% interest. Repayment schedule to be finalized upon co-generation project completion	**8,114**	4,723
Equipment loan, ten years with 0% interest. Repayment schedule to be finalized upon co-generation project completion	**2,203**	1,712
Mortgage loan due in monthly installments of $220, including interest at 3.04%, through October 1, 2041	**41,931**	43,262
	297,331	302,703
Less current portion	**8,226**	7,883
Less deferred financing costs	**2,916**	3,174
Long-term debt, net of current portion	**$ 286,189**	$ 291,646

Revenue Bonds

The Health System pays monthly debt service to the Bond Trustee to secure the 2009A, 2013A, and 2014A CCIA Revenue Bonds. The 2008A Revenue Bonds are credit-enhanced by a letter of credit agreement from a bank, which expires on January 29, 2021, 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, 2019 and 2018, the Health System has complied with these financial covenants.

(Dollars in Thousands)

8. Long-Term Debt and Lines of Credit (continued)

Interest Rate Swap Agreements

Under the swap agreements for the Series 2008A Bonds, the Health System pays interest at fixed rates and receives interest at variable rates. The swap agreement for the Series 2013A Bonds consists of a forward-starting SIFMA-based floating to fixed interest rate swap. The Health System pays interest at fixed rates and receives interest at variable rates. 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, 2019	$ 25,000	$ 25,000	$ 55,755
Effective date	March 23, 2009	March 9, 2009	November 27, 2019
Termination date	November 1, 2029	November 1, 2029	February 15, 2042
Fixed rate	2.577%	2.428%	1.627%
Variable rate basis	3-month USD-LIBOR-BBA	3-month USD-LIBOR-BBA	3-month USD-LIBOR-BBA
Fair value at December 31, 2019	$ (2,747)	$ (2,428)	$ 902
Fair value at December 31, 2018	$ (1,537)	$ (1,210)	$ –
Change in fair value for the year ended December 31, 2019	$ (1,210)	$ (1,218)	$ 902

During 2019 and 2018, the fair value of the interest rate swaps exceeded the mark-to-market value set forth in the agreement requiring collateral to be posted. Collateral posted totaled $1,370 and $570 at December 31, 2019 and 2018, respectively. The collateral balance is included within prepaid expenses and other current assets on the consolidated balance sheets.

Lines of Credit

The Health System has a revolving line of credit for $5,000 with a bank at December 31, 2019 and 2018. 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, 2020, 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, 2019 and 2018, there was $0 and $1,837 outstanding under the line of credit reported within accrued expenses.

(Dollars in Thousands)

8. Long-Term Debt and Lines of Credit (continued)

The Health System has a revolving line of credit for $125,000 with a bank at December 31, 2019. The agreement provides for interest at 1-Month Libor +70 basis points. The current line of credit has a 3-year term ending in November 2022. The line of credit includes financial covenants requiring a debt service coverage ratio of at least 1.25, a current ratio of at least 1.50, and at least 60 days cash on hand. To secure the line of credit, the Health System is granting to the bank a parity pledge under the MTI secured by the parity gross receipts of the Health System, and a parity mortgage pledge on certain real property. At December 31, 2019, there was $41,000 drawn and outstanding on the line of credit.

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
2020	$ 7,660	$ 507	$ 59	$ 8,226
2021	7,332	631	63	8,026
2022	7,550	784	68	8,402
2023	7,956	976	27	8,959
2024	8,375	1,213	–	9,588
Thereafter	230,376	13,673	–	244,049
	269,249	17,784	217	287,250
Net unamortized original issue premium	10,081	–	–	10,081
	$ 279,330	$ 17,784	$ 217	$ 297,331

9. 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 an investment fund (the Fund) through a promissory note (the Note) to be used for qualified equity investments in several CDEs. Interest on the Note accrued at 1.54% per annum with interest payments received quarterly. Principal payments were scheduled to be 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 was scheduled to mature 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 were made quarterly at a fixed interest rate of 1.1% per annum. Principal payments were scheduled to be made quarterly by CCC beginning December 2019 through September 2042. In October 2019, the seven-year compliance period for the new market tax credits ended. On October 30, 2019, the CDEs assigned their interest in the Agreements to the Fund and the Health System acquired 100% of the membership interest in the Fund. Approximately $6,515 of the outstanding balance of the Agreements was forgiven. The remaining $15,781 outstanding on the Agreements was offset by the Note owed to the Health System.

10. Retirement Plans

Defined Contribution Plan

The Health System sponsors a noncontributory defined contribution retirement plan covering all collective 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 $16,680 and $15,038 for the years ended December 31, 2019 and 2018, respectively.

Defined Benefit Plan

The Health System has a frozen noncontributory defined benefit pension plan (the Plan), which covered all employees who met certain criteria. During 2019, the Health System amended plan documents to allow for two risk-reduction programs. A vested termination cash out offering (VTCO) provided a one-time opportunity for vested terminated participants to elect a lump sum distribution in lieu of future annuity payments from the plan. Approximately 30% of eligible participants accepted the one-time offer resulting in lump sum payments totaling $7,964. In addition, the Health System implemented a retiree annuity buyout for small benefit retirees representing 1,016 retirees receiving benefits less than $800 a month. Annuities were purchased through a commercial insurer for the aforementioned group of retirees. A premium of $35,884 was paid and the commercial insurer retains the future benefit obligation of those retirees. The total settlement loss for these two programs was $10,157 and is included as a component of net periodic benefit cost.

(Dollars in Thousands)

10. Retirement Plans (continued)

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	
	2019	**2018**
Change in benefit obligation		
Projected benefit obligation at beginning of year	**$ 150,929**	$ 163,522
Interest cost	**6,009**	5,872
Plan settlements	**(43,848)**	–
Actuarial loss (gain)	**17,418**	(11,593)
Benefits paid	**(6,994)**	(7,097)
Expected administrative expenses	**–**	225
Projected benefit obligation, end of year	**$ 123,514**	$ 150,929
Accumulated benefit obligation	**$ 123,514**	$ 150,929
Change in plan assets		
Fair value of plan assets at beginning of year	**$ 129,757**	$ 143,876
Actual return on plan assets, net of expenses	**20,567**	(5,787)
Employer contribution to plan	**5,000**	–
Plan settlements	**(43,848)**	–
Benefits paid	**(6,994)**	(7,097)
Administrative expenses	**–**	(1,235)
Fair value of plan assets at end of year	**$ 104,482**	$ 129,757
Funded status at year-end – recognized on the consolidated balance sheets as accrued retirement benefits	**$ (19,032)**	$ (21,172)
Cumulative amounts recorded in accumulated net assets without donor restrictions consist of:		
Net unrecognized loss	**$ 26,879**	$ 38,318

(Dollars in Thousands)

10. 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 $2,161.

	2019	2018
Components of net periodic benefit cost and other amounts recorded in other changes in net assets without donor restrictions		
Net periodic benefit cost:		
Interest cost	**$ 6,009**	$ 5,872
Expected return on plan assets	**(4,837)**	(6,335)
Recognized actuarial loss	**3,387**	3,437
Settlement loss	**10,157**	–
	$ 14,716	$ 2,974
Other changes in pension benefit obligation recorded in other changes in net assets without donor restrictions:		
Increase to net assets without donor restrictions	**$ 11,439**	$ 1,448
Assumptions		
Weighted average assumptions used to determine benefit obligations at December 31:		
Discount rate	**3.31%**	4.34%
Rate of compensation increase	**N/A**	N/A
Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:		
Discount rate	**4.34%**	3.66%
Expected long-term return on plan assets	**5.60%**	5.60%
Rate of compensation increase	**N/A**	N/A

(Dollars in Thousands)

10. Retirement Plans (continued)

Due to the plan settlements as previously described, remeasurements of the plan's benefit obligation were performed as of October 31, 2019 and November 30, 2019. The discount rates used in the remeasurements as of October 31, 2019 and November 30, 2019, were 3.20% and 3.19%, respectively.

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% long-term rate of return on assets assumption used in 2019 and 2018.

	Asset Allocation			December 31	
	Minimum	**Target**	**Maximum**	**2019**	**2018**
Plan assets					
Weighted average asset allocations, by asset category:					
Equity securities	30%	20%	10%	**20%**	16%
Debt securities	90	80	70	**80**	84
				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.

(Dollars in Thousands)

10. Retirement Plans (continued)

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, 2019				
Money market funds	**$ 194**	**$ 194**	**$ –**	**$ –**
U.S. Treasury securities	**14,016**	**14,016**	**–**	**–**
Mutual funds	**90,272**	**90,272**	**–**	**–**
	$ 104,482	**$ 104,482**	**$ –**	**$ –**
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	$ –	$ –

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 2020	$ 5,000

Estimated Future Benefit Payments

2020	$ 5,606
2021	5,976
2022	6,427
2023	6,724
2024	6,992
2025–2029	36,610

(Dollars in Thousands)

11. 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	
	2019	**2018**
Employee health benefits	**$ 5,640**	$ 5,064
Workers' compensation	**6,014**	5,649
Professional and general liability	**77,012**	67,826
	88,666	78,539
Less current portion of self-insured reserves	**26,363**	25,421
	$ 62,303	$ 53,118

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 to $50,000.

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, 2019, 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).

11. Self-Insured Reserves (continued)

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

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

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

12. Commitments and Contingencies

At December 31, 2019, 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.

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

(Dollars in Thousands)

12. Commitments and Contingencies (continued)

have not been accrued at December 31, 2019, 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 records the escrow deposit within assets limited as to use as of December 31, 2019 and 2018. 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.

13. Net Assets with Donor Restrictions

Net assets with donor restrictions are as follows:

	December 31	
	2019	**2018**
Purpose – various funds for benefit of the departments, programs, or educational programs of the Health System	**$ 45,133**	$ 37,827
Time restricted – pledges	**439**	441
Permanent endowments – to be maintained in perpetuity	**2,585**	2,585
Total net assets with donor restrictions	**$ 48,157**	$ 40,853

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.

(Dollars in Thousands)

13. Net Assets with Donor Restrictions (continued)

The Health System has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. 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.

Endowments to be maintained in perpetuity consist of the following:

	December 31	
	2019	**2018**
Women's Board	**$ 1,042**	$ 1,029
Radiology	**501**	501
Lummis Trust	**235**	218
Nursing education	**171**	171
Cleft Palate program	**107**	107
Lippincott	**61**	–
Nispel Estate	**16**	16
Physical teaching and excellence award	**13**	13
Other	**439**	530
Total endowments	**$ 2,585**	$ 2,585

The investment income earned on the above endowments is to be used to support patient care services, with the exception of the Nispel Estate, Lippincott 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.

(Dollars in Thousands)

13. Net Assets with Donor Restrictions (continued)

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	
	2019	**2018**
Purpose:		
Various funds for benefit of the departments, programs, or educational programs of the Health System	**$ –**	$ 421
	$ –	$ 421

14. Other Revenue

Other revenue consists of the following:

	Year Ended December 31	
	2019	**2018**
Grant revenue	**$ 19,525**	$ 19,843
Medical school support	**7,663**	2,800
Food services	**6,916**	6,546
Centers for population health	**2,919**	1,642
Retail pharmacy cost sharing	**13,440**	13,193
Physician services	**16,121**	16,293
Emergency/air transport	**7,489**	7,588
Net assets released from restrictions for operating purposes	–	421
Other	**9,362**	15,021
	$ 83,435	$ 83,347

The Health System received approximately $10,210 in government grants which include conditions and restrictions which were not satisfied as of December 31, 2019, and such amount is reported within accrued expenses on the accompanying 2019 consolidated balance sheet.

(Dollars in Thousands)

15. Functional Expenses

The Health System provides general health care services to residents within its service area. The accompanying consolidated financial statements report certain expense categories that are attributable to more than one health care service or support function. Costs not directly attributable to a function are allocated on a functional basis based on Health System's internal records and estimates. Expenses by function and natural classification are as follows:

	Health Care Services	Physician Services	General and Administrative	Total
Year ended December 31, 2019				
Salaries, wage, and fringe benefits	**$ 286,963**	**$ 380,695**	**$ 151,687**	**$ 819,345**
Supplies and other	**341,981**	**47,899**	**84,794**	**474,674**
Malpractice	**–**	**13,973**	**16,437**	**30,410**
Depreciation and amortization	**–**	**1,963**	**53,834**	**55,797**
Interest	**–**	**–**	**13,622**	**13,622**
	$ 628,944	**$ 444,530**	**$ 320,374**	**$ 1,393,848**
Year ended December 31, 2018				
Salaries, wage, and fringe benefits	$ 259,259	$ 351,573	$ 138,159	$ 748,991
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	$ 244,190	$ 1,261,749

16. 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 $5,563 and $2,391 of state appropriation during the years ended December 31, 2019 and 2018, respectively.

17. Subsequent Events

The Health System has evaluated subsequent events through April 23, 2020, the date when the accompanying consolidated financial statements were issued. Except as disclosed below, no subsequent events have occurred that require disclosure in or adjustment to the accompanying consolidated financial statements.

Due to the global viral outbreak caused by Coronavirus Disease 2019 (COVID-19) in 2020, there have been resulting effects which could negatively impact the Health System's financial condition, including significant stock market exchange volatility, including various temporary volatility trading halts which commenced initially on March 9, 2020, due to market declines, various temporary business closures and event cancellations, and other effects which could result in supply disruptions and/or decisions to defer elective procedures and other medical treatments at the Health System as the broader economic impact of COVID-19 develops. Management continues to closely monitor the impact of COVID-19 in many respects. To enhance available liquidity, the Health System is participating in the Centers for Medicare & Medicaid Services' Accelerated and Advance Payment Program under which Cooper University Health System received expedited payments for future services; the advance payment will be recouped over time as Medicare services are provided after a 120-day delay period, with a final repayment of any remaining balance due in April 2021. The Health System also received an initial grant distribution under the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

Supplementary Information

The Cooper Health System

Consolidating Balance Sheet
(In Thousands)

December 31, 2019

	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	$ 328,894	$ –	$ –	$ 328,894	$ 15,616	$ –	$ –	$ 15,780	$ –	$ 360,290
Current portion of assets limited as to use	28,374	–	–	28,374	–	–	–	–	–	28,374
Patient accounts receivable, net	146,719	–	–	146,719	–	–	–	–	–	146,719
Prepaid expenses and other current assets	49,482	–	–	49,482	(51)	48	–	403	–	49,882
Due from affiliates	20,499	32,356	(32,356)	20,499	–	480	–	–	(20,979)	–
Total current assets	573,968	32,356	(32,356)	573,968	15,565	528	–	16,183	–	585,265
Assets limited as to use:										
Internally designated by Board of Trustees	256,377	–	–	256,377	–	–	–	–	–	256,377
Externally designated for donor purposes	–	–	–	–	54,808	–	–	–	–	54,808
Externally designated under debt agreements, net of current portion	3,866	–	–	3,866	–	–	–	–	–	3,866
Externally designated – escrow agreement	15,011	–	–	15,011	–	–	–	–	–	15,011
Designated under self-insurance programs, net of current portion	25,790	–	–	25,790	–	–	–	–	–	25,790
Assets limited as to use, net of current portion	301,044	–	–	301,044	54,808	–	–	–	–	355,852
Property, plant, and equipment, net	587,802	–	–	587,802	–	–	871	11,555	–	600,228
Operating lease assets, net	56,513	–	–	56,513	–	–	–	–	–	56,513
Other assets, net	1,076	–	–	1,076	507	–	11,414	–	–	12,997
Due from affiliates	–	–	–	–	–	–	–	31,422	(31,422)	–
Total assets	$ 1,520,403	$ 32,356	$ (32,356)	$ 1,520,403	$ 70,880	$ 528	$ 12,285	$ 59,160	$ (52,401)	$ 1,610,855
Liabilities and net assets										
Current liabilities:										
Accounts payable	$ 56,092	$ –	$ –	$ 56,092	$ –	$ –	$ –	$ –	$ –	$ 56,092
Accrued expenses	143,242	–	–	143,242	–	(20)	–	548	–	143,770
Current portion of estimated settlements due to third-party payers	342	–	–	342	–	–	–	–	–	342
Current portion of self-insured reserves	26,363	–	–	26,363	–	–	–	–	–	26,363
Current portion of long-term debt	6,847	–	–	6,847	–	–	52	1,327	–	8,226
Current portion of operating lease liability	15,239	–	–	15,239	–	–	–	–	–	15,239
Line of credit advances	41,000	–	–	41,000	–	–	–	–	–	41,000
Due to affiliates	32,356	–	(32,356)	–	10,540	–	8,924	1,515	(20,979)	–
Total current liabilities	321,481	–	(32,356)	289,125	10,540	(20)	8,976	3,390	(20,979)	291,032
Estimated settlements due to third-party payers, net of current portion	11,145	–	–	11,145	–	–	–	–	–	11,145
Accrued retirement benefits	19,032	–	–	19,032	–	–	–	–	–	19,032
Self-insured reserves, net of current portion	62,303	–	–	62,303	–	–	–	–	–	62,303
Long-term debt, net of current portion	245,501	–	–	245,501	–	–	165	40,523	–	286,189
Operating lease liability, net of current portion	42,442	–	–	42,442	–	–	–	–	–	42,442
Deferred revenue and other liabilities	19,211	–	–	19,211	–	–	–	1,851	–	21,062
Due to affiliates	31,422	–	–	31,422	–	–	–	–	(31,422)	–
Total liabilities	752,537	–	(32,356)	720,181	10,540	(20)	9,141	45,764	(52,401)	733,205
Net assets:										
Without donor restrictions	767,427	32,356	–	799,783	12,622	548	3,144	13,396	–	829,493
With donor restrictions	439	–	–	439	47,718	–	–	–	–	48,157
Total net assets	767,866	32,356	–	800,222	60,340	548	3,144	13,396	–	877,650
Total liabilities and net assets	$ 1,520,403	$ 32,356	$ (32,356)	$ 1,520,403	$ 70,880	$ 528	$ 12,285	$ 59,160	$ (52,401)	$ 1,610,855

The Cooper Health System

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

Year Ended December 31, 2019

	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	$ 1,355,977	$ –	$ –	$ 1,355,977	$ –	$ –	$ –	$ –	$ –	$ 1,355,977
Other revenue	84,237	1,380	(1,380)	84,237	544	341	1,211	7,005	(9,903)	83,435
Total revenue	1,440,214	1,380	(1,380)	1,440,214	544	341	1,211	7,005	(9,903)	1,439,412
Expenses:										
Salaries, wages, and fringe benefits	819,004	–	–	819,004	–	341	–	–	–	819,345
Supplies and other	476,947	207	(1,380)	475,774	4,301	182	351	3,969	(9,903)	474,674
Malpractice	30,410	–	–	30,410	–	–	–	–	–	30,410
Depreciation and amortization	51,103	3,620	–	54,723	–	–	37	1,037	–	55,797
Interest	12,067	229	–	12,296	–	–	15	1,311	–	13,622
Total expenses	1,389,531	4,056	(1,380)	1,392,207	4,301	523	403	6,317	(9,903)	1,393,848
Operating income (loss)	50,683	(2,676)	–	48,007	(3,757)	(182)	808	688	–	45,564
Nonoperating gains and losses:										
Investment return	25,730	–	–	25,730	516	–	(734)	–	–	25,512
Net change in unrealized gains and losses on trading securities	4,722	–	–	4,722	5,842	–	–	–	–	10,564
Net change in unrealized gains and losses on other than trading equity securities	2,619	–	–	2,619	–	–	–	–	–	2,619
Gain on forgiveness of note payable	–	6,515	–	6,515	–	–	–	–	–	6,515
Change in value of equity method investments	–	–	–	–	–	–	–	998	–	998
Net periodic pension cost	(14,716)	–	–	(14,716)	–	–	–	–	–	(14,716)
Change in fair value of interest rate swap agreements	(1,526)	–	–	(1,526)	–	–	–	–	–	(1,526)
Other losses	(5,129)	–	–	(5,129)	–	–	–	–	–	(5,129)
Excess (deficiency) of revenue over expenses	62,383	3,839	–	66,222	2,601	(182)	74	1,686	–	70,401
Other changes in net assets without donor restrictions:										
Change in pension benefit obligation	11,439	–	–	11,439	–	–	–	–	–	11,439
Contributions received and expended for capital acquisitions	13,365	–	–	13,365	–	–	–	–	–	13,365
Net change in unrealized gains and losses on other-than-trading securities	2,928	–	–	2,928	–	–	–	–	–	2,928
Increase (decrease) in net assets without donor restrictions	90,115	3,839	–	93,954	2,601	(182)	74	1,686	–	98,133
Net assets with donor restrictions										
Contributions, gifts, and special events, net of fundraising expenses	–	–	–	–	4,451	–	–	–	–	4,451
Income from investments	–	–	–	–	1,009	–	–	–	–	1,009
Net realized and unrealized gains on investments	–	–	–	–	1,844	–	–	–	–	1,844
Net assets released from restrictions for operating purposes	–	–	–	–	–	–	–	–	–	–
Increase in net assets with donor restrictions	–	–	–	–	7,304	–	–	–	–	7,304
Increase (decrease) in net assets	90,115	3,839	–	93,954	9,905	(182)	74	1,686	–	105,437
Net assets, beginning of year	677,751	28,517	–	706,268	50,435	730	3,070	11,710	–	772,213
Net assets, end of year	$ 767,866	$ 32,356	$ –	$ 800,222	$ 60,340	$ 548	$ 3,144	$ 13,396	$ –	$ 877,650

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